Patient Information Questionnaire

please fill out this form as much as possible - all responses are strictly confidential
- save File, then bring in this form on your initial visit or email it back to us -
we will review all information with you and complete as necessary

Click to Lock File ONLY When Completed

Name: _____ Date: _____

A. HISTORY OF PRESENT PROBLEM:

1. Problem requiring Physiotherapy?

☐ pain ☐ numbness ☐ tingling ☐ swelling ☐ weakness ☐ stiffness ☐ dizziness ☐ balance

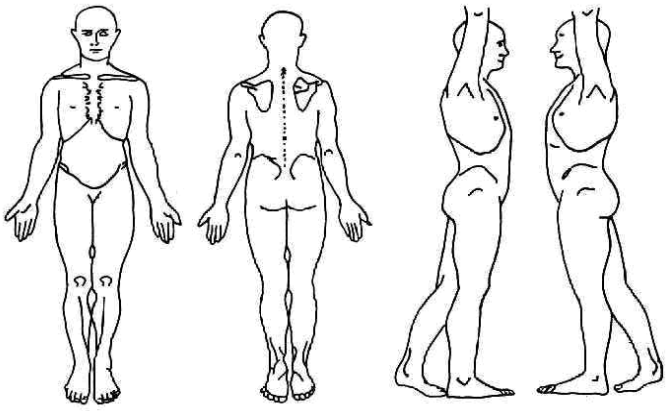
☐ Other: _____

2. Is the pain or problem: (some areas may behave differently than others)

☐ constant ☐ periodic ☐ occasional ☐ increasing ☐ decreasing ☐ not changing ☐ _____

3. Please mark the present problem area(s) on this body diagram:

(i.e., what sensations do you feel and where do you feel them)
- use these symbols on diagram as appropriate -
(To draw on diagram or pain scales: use the Comment Tool --> Drawing Tool)



☐ pain (xx)
☐ radiating (-->)
☐ sharp (**)
☐ stabbing (SS)
☐ aching (AA)
☐ Other: _____

☐ numbness (oo)
☐ tingling, pins, needles (///)
☐ dull (DD)
☐ burning (##)
☐ catching/grabbing (CC)

Hand Dominance: ☐ Right ☐ Left ☐ Both

4. Indicate the level / intensity of your pain on the scales below:

Today/Now: |----------| On a scale of 0 to 10: ____
(0) no pain worst pain (10)

At Worst Times: |----------| On a scale of 0 to 10: ____

5. What caused the present problem?

☐ injury at home ☐ injury at work (date: _____) ☐ motor vehicle accident (date: _____)
☐ sporting or leisure activity ☐ long standing problem ☐ unknown
☐ Other: _____

6. Can you briefly describe WHEN and HOW it occurred?

7. Do any of the following make this problem WORSE or INCREASE the pain?

☐ walking
☐ standing
☐ sitting
☐ sleeping / lying down arising
☐ in the morning during the
☐ course of the day by the end
☐ of the day
☐ up or down stairs (hills)

☐ prolonged time in one position
☐ movement out of a prolonged position
☐ changes in position at any time
☐ rising up out of a chair
☐ increase in activity levels (work / home)
☐ decrease in activity / movement
☐ increase in stress / tension
☐ other: _____

☐ leisure activities / sports
☐ work activities
☐ self care / dressing
☐ using arms above the head
☐ lifting / carrying
☐ bending / twisting
☐ coughing / sneezing / deep breath
☐ _____

8. What do you find helps to DECREASE your pain, and/or helps to IMPROVE your condition? *(Self-treatment? Other treatments?)*

9. If this, or a similar, problem has occurred before, when and how did this happen?

(continue next page-->)

10. What has been done for THIS problem to date?

☐ medical specialists ☐ psychology / counseling ☐ social work ☐ occupational therapy ☐ massage
☐ physiotherapy ☐ osteopathic ☐ chiropractic ☐ acupuncture ☐ kinesiologist
☐ Other: _____

- Results of treatment:

_____

11. Tests or other procedures done for THIS problem: (specify dates, where, type, procedure, if possible ?)

☐ x-rays: _____ ☐ CT Scan / MRI: _____
☐ US Scan / Bone Scan: _____ ☐ surgery: _____
☐ blood tests, Bone Density: _____ ☐ other: _____

B. PAST MEDICAL HISTORY:

1. List any OTHER medical conditions affecting your health:

☐ high blood pressure / circulation / swelling of feet ☐ headaches / dizziness ☐ osteoarthritis (OA)
☐ heart or lung / breathing problems ☐ seizures / blackouts ☐ rheumatoid arthritis (RA)
☐ pacemaker ☐ ringing in ears / tinnitus ☐ osteoporosis
☐ metal pins, screws or total joint replacement ☐ diabetes / thyroid ☐ allergies
☐ loss of bowel / bladder function ☐ gastrointestinal / ulcer / kidney ☐ dental / TMJ
☐ neurological / stoke / Parkinson's ☐ pregnancy ☐ cancer
☐ Other: _____

2. Significant medications you are PRESENTLY taking: (benefits? side effects?)

_____

3. List other RECENT major surgery:

_____

C. EMPLOYMENT and SOCIAL HISTORY:

1. Occupation: ☐ employed *(continue with 1. a), b), and c) below)* ☐ retired ☐ student

a) Are you presently able to work?

☐ yes, this problem does not affect my work ☐ yes, full time, but work aggravates my condition
☐ yes, part time, I can only tolerate a reduced workload ☐ no, but I am able to do light workloads
☐ no, I am totally unable to do my normal workloads ☐ Other: _____

b) List any critical demands, workloads or body positioning you normally are required to do at work:

_____

c) If your work / activity level is significantly limited, are there any tasks you are presently able to do?:

_____

2. List any sports, hobbies or leisure activities you are normally involved in or doing: *(include any you are <u>now</u> unable to do)*:

_____

3. Do you require assistance at home? if yes, please specify (i e. Homemaker):

☐ no ☐ yes _____

4. Is transportation a problem for you? if yes, list any details, such as requiring a taxi or HandiDart:

☐ no ☐ yes _____

D. GOALS: *(optional - if appropriate)*

1. What specifically do YOU hope to accomplish with treatment? (select as many as applicable)

☐ no more pain ☐ reduction of pain ☐ self-management of pain ☐ improvement with activities
☐ increased strength ☐ increased mobility ☐ return to sport ☐ return to work
☐ Other: _____

What do you feel your problem needs to get better?

_____

PHYSIOTHERAPIST'S SIGNATURE *(if therapist adds any information):* _____