



# Patient Data

*Your Privacy is important to us. We do not share personal information with anyone without your consent.*

## General Information

(Please Print all information)

Full Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Email \_\_\_\_\_

Sex  Male  Female

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Marital Status  Single  Married  Divorced  Widow(er)

How did you find out about us? \_\_\_\_\_

Who is responsible for this account?  Patient  Other \_\_\_\_\_  
(Give details)

## Contact Information

Emergency Contact Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Describe the problem(s) for which you now require treatment**

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**Date of onset of injury or symptoms** \_\_\_/\_\_\_/\_\_\_\_\_

**Are you seeing anyone else for these problem(s)?**

(Check all that apply)

- Acupuncturist
- Cardiologist
- Chiropractor
- Dentist
- Family Doctor
- Internist

- Massage Therapist
- Neurologist
- Obstetrician/Gynecologist
- Occupational Therapist
- Orthopedist
- Osteopath

- Pediatrician
- Podiatrist
- Primary Care Physician
- Rheumatologist
- Other \_\_\_\_\_

(Give details)

**Referring Doctor** \_\_\_\_\_

**Describe any other treatment you have received or are receiving for this injury**

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**Please answer the following questions regarding your pain / symptoms:**

Do you have pain all the time  
Pain is worse in  
Pain intensity

- Yes
- No
- Morning
- Afternoon
- Evening
- Night
- Constant
- Fluctuates/Changes

**What activities make your pain or symptoms worse?**

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**What activities relieve your pain or symptoms?**

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## Patient Pain Rating

Visually representing your pain will help us make a more accurate diagnosis.

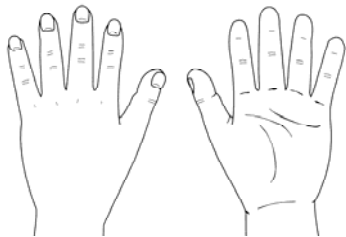
**Please mark on the line the intensity of your pain / symptoms**

	(No Pain)		(Worst Pain ever)
Now		-----	
Least		-----	
Worst		-----	

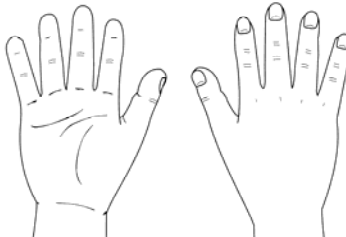
**Please mark on the diagram the location and type of pain you are experiencing**

Use the following symbols to represent the type of pain:

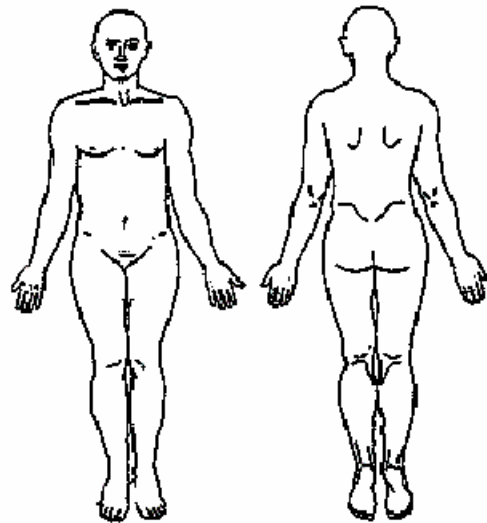
Dull or Achy	///
Burning	>>>
Sharp	XXX
Shooting	+++



**Left**



**Right**



**Please list three activities you have difficulty performing because of your pain or symptoms**

Mark on the line the degree of difficulty you have when performing these activities

	(Minor difficulty)		(Unable to perform)
1. _____		-----	
2. _____		-----	
3. _____		-----	

## Living Environment

### Where do you live?

(Check all that apply)

Private Home

Private Apartment

Rented Room

Hospice

Board and Care / Assisted Living / Group Home

Long-term care facility

Homeless (with or without shelter)

Other \_\_\_\_\_

(Give details)

### With whom do you live?

(Check one only)

Alone

Spouse (only)

Spouse and children

Child (no spouse)

Other Relatives

Group Setting

Personal care attendant

Other \_\_\_\_\_

(Give details)

### Does your home have any of the following?

(Check all that apply)

Stairs, with railing

Stairs, no railing

Ramps

Lift

Uneven terrain

Obstacles \_\_\_\_\_

(Give details)

Assistive devices

(eg grab bars in the bathroom)

### Do you use any assistive devices?

(Check all that apply)

Cane

Walker or Rollator

Other \_\_\_\_\_

(Give details)

Manual Wheelchair

Motorised Wheelchair

Glasses

Hearing Aid

### Employment Status

(Check one only)

Working Full-time outside of home

Working Full-time from home

Working Part-time outside of home

Working Part-time from home

Retired

Unemployed

Student

Occupation \_\_\_\_\_

## Medical History

**Have you ever had, or been told that you have, any of the following?**

(Indicate Yes or No and give details as appropriate)

				Details
Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Low Blood Sugar	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Angina or Chest Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Shortness of Breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Broken Bones / Fractures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Lung Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Multiple Sclerosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Parkinson's Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Allergies	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ulcer / Stomach Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Depression	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Arthritis / Gout	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Osteoporosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Thyroid Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Fibromyalgia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Polio	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Circulation/Vascular Problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood Disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Head Injury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Muscular Dystrophy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Seizures/Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Development/Growth Problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Infectious Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Repeated Infections	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Skin Diseases	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**Have you ever had surgery?**

Yes  No

(If yes, please describe and include dates)

	Month	Year
_____	(____)	(____)
_____	(____)	(____)
_____	(____)	(____)
_____	(____)	(____)
_____	(____)	(____)



## General Health

Please list below any prescription, over the counter medications or nutritional supplements that you are taking, and for what condition:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Have you had any unexplained weight gain or loss in the last month?     No     Gain     Loss

Are you or could you be pregnant?     Yes     No

Do you smoke or chew tobacco?     Yes     No

On average, how many packs per day? \_\_\_\_\_

How long have you used tobacco products?     Years     Months

Do you drink alcoholic beverages?     Yes     No

On average, how many drinks per week? \_\_\_\_\_

Do you have a pacemaker, transplanted organs or metal implants?     Yes     No

If yes, please specify

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How many times do you exercise per week? \_\_\_\_\_    How many minutes per session? \_\_\_\_\_

Describe a typical exercise routine

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Any additional comments

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