Portage PHYSIOTHERAPY

PART OF THE *inMotion* NETWORK

PHYSIOTHERAPY MEDICAL QUESTIONNAIRE

Please note that under the Federal Privacy Legislation, you have the ***right to refuse to disclose*** any part(s) of your personal information to us. As long as the absence of the information does not compromise our ability to provide you with safe and effective care then physiotherapy services may continue to be provided.

Client Name: _____ Date of Birth (D/M/Y): _____

Physician: _____ Were you referred by your Doctor? ❑ Yes ❑ No

Occupation: _____

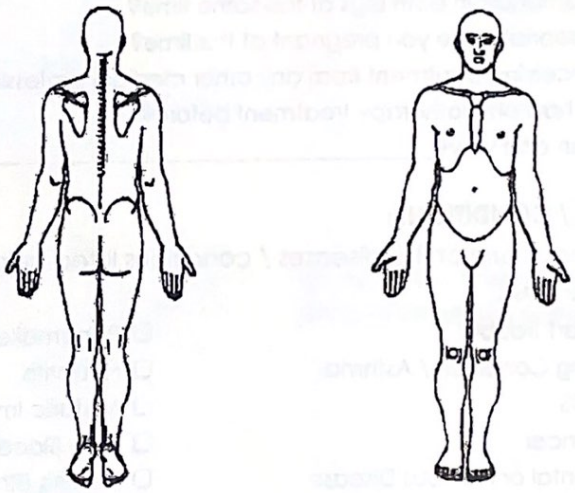
Are you currently off work due to your condition/injury/problem? ❑ Yes ❑ No

Is this condition/injury covered by?

❑ **WCB** ❑ **MPI** Email _____

AREA OF SYMPTOMS:

Please MARK the areas of:
Pain with /////,
Numbness or Tingling with **XXX**.



DESCRIPTION OF SYMPTOMS:

How long have you had the complaint you are attending for? _____

Are your symptoms a result of a specific injury? ❑ Yes ❑ No
If so, please specify date of injury. _____; and provide brief description of the injury _____.

How would you describe your pain?

❑ Shooting ❑ Aching *(check one)* ❑ Constant ❑ Periodic *(check one)*

If you experience morning stiffness, does it generally last?

❑ Less than 15 mins. ❑ Less than 2 hours ❑ More than 2 hours

What makes your symptoms better? _____

What makes your symptoms worse? _____

Does your pain increase, decrease or stay the same as the day goes on? _____

MEDICAL HISTORY / PREVIOUS TESTS

List all medications you are currently taking: _____

_____

Have you had any X-ray / CT Scan / MRI / or other Diagnostic Tests for this problem?

❑ Yes ❑ No If YES, where and when? _____

Please list any previous surgeries: _____

Please check Yes or No to the following questions:

Does coughing or sneezing make your pain worse?	❑ Yes ❑ No
Any recent unexplained bowel or bladder changes?	❑ Yes ❑ No
Any dizziness or fainting attacks?	❑ Yes ❑ No
Any unexplained falls or changes in balance?	❑ Yes ❑ No
Any numbness or tingling in the saddle (groin) region?	❑ Yes ❑ No
Are you taking blood thinners?	❑ Yes ❑ No
Any unexplained changes in your vision?	❑ Yes ❑ No
Any nausea, vomiting, diarrhea or fever?	❑ Yes ❑ No
Any unexplained changes in your weight?	❑ Yes ❑ No
Any numbness in both legs at the same time?	❑ Yes ❑ No
If appropriate, are you pregnant at this time?	❑ Yes ❑ No
Are you receiving treatment from any other medical professionals?	❑ Yes ❑ No
Have you had physiotherapy treatment before?	❑ Yes ❑ No

If yes, when and why? _____

DISEASES / CONDITIONS:

Please check any of the diseases / conditions listed below which you presently have, or have had in the past.

- ❑ Heart Trouble
- ❑ Lung Condition / Asthma
- ❑ AIDS
- ❑ Cancer
- ❑ Mental or Nervous Disease
- ❑ Crohn's Disease / Colitis
- ❑ Pacemaker
- ❑ Hepatitis
- ❑ Metallic Implants
- ❑ High Blood Pressure
- ❑ Arthritis (Rheumatoid or Osteoarthritis)
- ❑ Diabetes
- ❑ Other: _____

I understand that I am attending for Physiotherapy and that the assessment and treatment will be provided by a licenced Physiotherapist. I understand that this facility will make every reasonable effort to ensure that all personal information is kept private and confidential.

❑ **Yes** ❑ **No**

I have read the above information and indicate my consent by checking off the applicable boxes, completing the required information and by signing this form.

_____ _____ _____

Client Signature **Date** **Physiotherapist Signature**

Notice: To assist those clients who may be on our waiting list, we ask that you contact the clinic 24 hours prior to your scheduled appointment time if you are unable to attend. Failure to give sufficient notice may result in a cancellation fee of $35.