

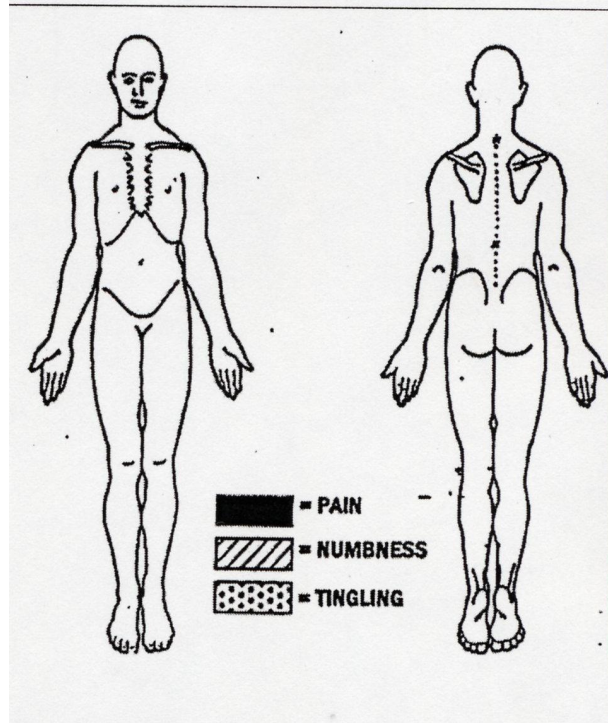
PHYSICAL THERAPY

CONFIDENTIAL CLIENT QUESTIONNAIRE

Name:	Date of Birth Dd ____ mm ____ yyyy ____	Occupation:
Address		Postal Code
Town		
Telephone Numbers: Home: _____ Work _____ Cell: _____		
Health Card Number: _____		
<p>1. Referred By: _____</p> <p>(a) Problem you were referred for: _____</p> <p>_____</p> <p>_____</p> <p>Have you had any of the following tests done?</p> <p><input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI <input type="checkbox"/> CT scan <input type="checkbox"/> None Date: _____</p>		
<p>2. a) Is your problem due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Date of Injury: _____</p> <p>Are you currently off work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>Insurance Coverage: Please indicate claim number and case worker's name if applicable</p> <p>WCB: _____</p> <p>SGL: _____</p> <p>Other: _____</p>		
<p>3. List any other health conditions you may have: (i.e surgeries, heart, diabetes, asthma, cancer, seizures, pregnancy, pacemaker etc.)</p> <p>_____</p>		
<p>4. Are you currently taking medications/Supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please List:</p>		
<p>5. Which of the following describes your symptom(s)?</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Unstable Joint <input type="checkbox"/> Loss of function <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Productive cough <input type="checkbox"/> Other – specify: _____</p>		
<p>6. How long have you had this problem? <input type="checkbox"/> Up to 6 weeks <input type="checkbox"/> 6 weeks to 3 months</p> <p><input type="checkbox"/> Over 3 months, Specify: _____</p>		

7. Overall, are you getting: Better No Change Worse

8. a) Please mark the areas on your body (using the diagram) where you feel the described sensations. Use the appropriate symbol. Include all affected areas
Comments:



b) Circle the number that describes you pain during work or activity.

0	1	2	3	4	5	6	7	8	9	10
Pain Free	Mild	Moderate pain		Strong pain		Severe pain		Pain		
		Slightly limits activity		significantly limits activity		unable to work		Intolerable (emergency)		

9. Is your pain/symptom worse: When active/working

When inactive (ie. Watching TV)

10. a) Does your symptom(s) keep you from falling asleep at night? Yes No

b) Does your symptom(s) wake you during the night? Yes No

11. Is your symptom(s) Occasional Frequent Constant

12. What makes your symptom(s) worse?

13. What eases your symptom(s) heat cold rest activity

Other, Specify:

14. What treatment(s)/services(s) have you had for this problem?

Treatment/Service	Did the treatment help?		Last Seen?
	Yes	No	
Physical Therapy			
Occupational Therapy			
Chiropractic			
Massage			
Acupuncture			
Other			

15. How active is your lifestyle?

- Very active
- Active
- Non active

16. What recreational activities and hobbies do you regularly participate in?

17. How did you hear about Regina Rehab and Family Medical Clinic?

- Referred by doctor/health care worker
- Word of mouth
- Phone Book
- Radio
- Website
- Other (please list) _____

The above information is true, accurate and complete to the best of my knowledge.

Signed: _____ Date: _____