



HealthWorks

Physiotherapy Massage Therapy Acupuncture

Medical Office Wing
1440 – 14th Avenue
Regina, SK
S4P 0W5

ADMISSIONS QUESTIONNAIRE

Name: _____

Date: _____

Doctor: _____ Hosp#: _____ Birthdate: _____

A. Present Problem

1. Date of Injury/Onset of Problem: _____
2. Was your problem due to: Motor vehicle accident Work Injury Disease
 Sport Other _____
3. How did your problem begin? _____

4. What did you do immediately following the onset of your problem and since then?

5. Was the onset sudden or gradual
6. Did you awaken with the problem? yes no
7. Did you hit your head? yes no
If yes, did you loose consciousness? yes no
8. Have you seen your doctor regarding this problem? yes no
If yes, Dr. _____
Recommendations? _____
9. Have you seen a specialist? yes no
If yes, Dr. _____
Recommendations? _____
10. Have you been treated for this problem by:

Physiotherapist	<input type="checkbox"/> yes <input type="checkbox"/> no	Helped?	<input type="checkbox"/> yes <input type="checkbox"/> no
Chiropractor	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
Massage Therapist	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
Acupuncturist	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
11. Have x-rays been done? yes no
Where? _____ When? _____

12. What is your primary problem? I.e. pain, decreased movement, stiffness
(Please list in order of severity if more than one problem)
a. _____ b. _____ c. _____
13. Have you had this problem before? yes no

B. Activity Level

1. Occupation: _____
2. Presently working? yes no
Do you normally work full time part time _____ hrs/day or _____ days/wk
If working, is it full duties partial duties; Is it normal hours? yes no
If not working, would modified or alternate duties be available?
3. Type of job duties: _____

4. List work, home and recreational activities that you are UNABLE to do now:

-
5. List work, home and recreational activities that you are ABLE to do with difficulty:

6. Do you exercise regularly? yes no
If yes, what type of exercise? _____
How often? _____

WCB/SGI Clients ONLY

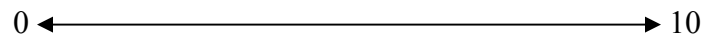
7. Name of employer: _____ Phone #: _____
Name of supervisor: _____

C. Sleep Pattern

1. Do you sleep through the night? yes no
If no, what awakens you? _____
How often do you awaken in the night? _____
Do you get out of bed due to pain? yes no
Do you have trouble falling asleep? yes no
2. What position do you USUALLY sleep in?
 stomach back left side right side
Can you still sleep in this position now? yes no
3. What type of bed do you sleep on?
 firm box spring/mattress soft box spring/mattress waterbed futon
4. How many pillows do you use? _____ Where do you place them? _____
Do you have an orthopedic pillow? yes no

D. Pain

1. Please rate your pain in the last 24 hours with the numerical scale below:
0 is no pain and 10 is the worst pain you could imagine

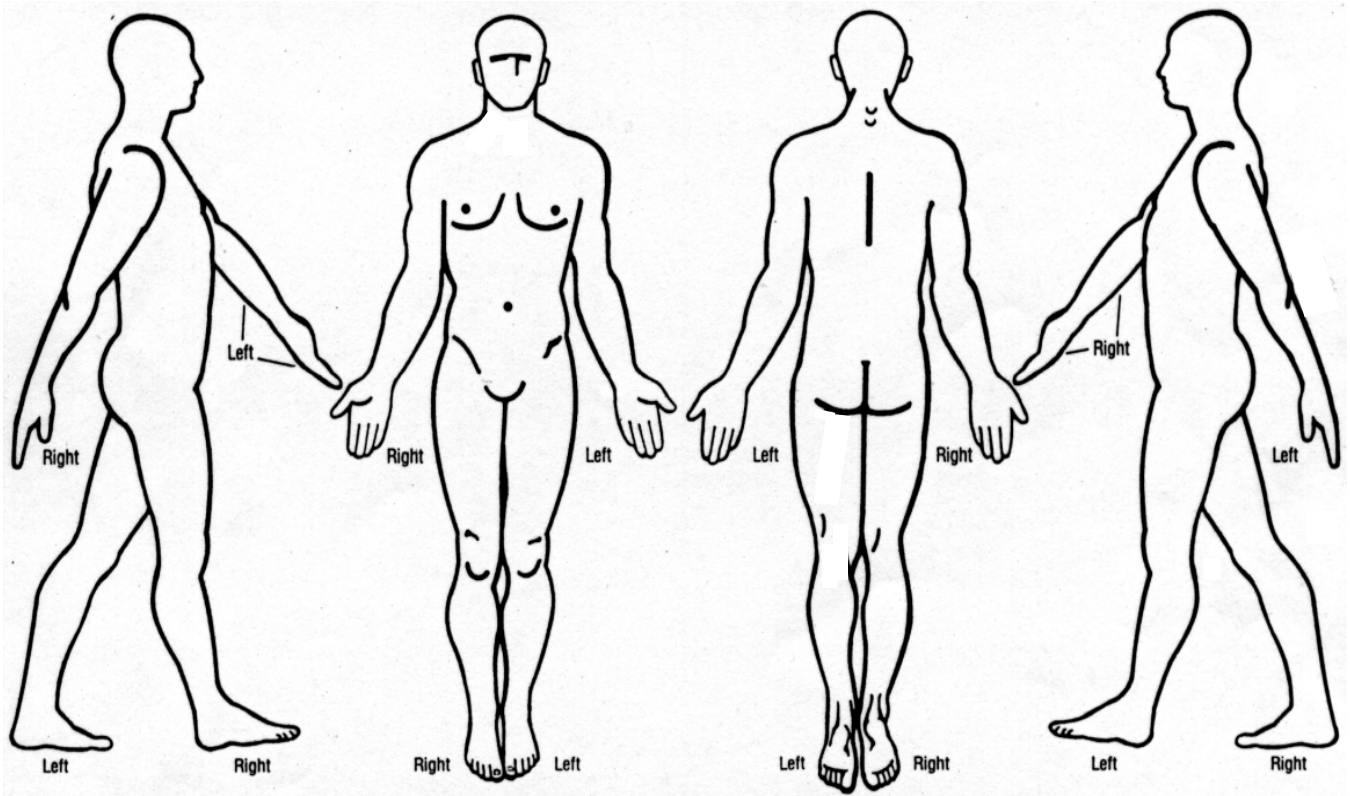


2. What does your pain feel like?
 dull ache sharp line throbbing tight
 burning twinge stabbing other _____

3. Is the pain constant intermittent

3. Mark the body chart below as to how you feel NOW with an:

X for pain //// for pins and needles
 for numbness ↘ for traveling pain



4. In the past 2 weeks, has your pain: increased decreased stayed the same
5. What makes it worse?
 sitting lying kneeling climbing stairs reaching overhead
 standing bending walking turning in bed driving
 other _____
6. What makes it better?
 rest medication heat ice exercise changing position or activity

7. When is your pain worse?
 morning mid-day evening night depends upon activity
8. How do you feel in the morning?
 rested sore stiff (How long? _____)
 better than when you went to bed worse than when you went to bed
9. Does coughing/sneezing increase your pain? yes no
10. Do you have pain when taking a deep breath? yes no
11. Do you have problems with your bowels bladder
 constipation diarrhea urgency incontinence
12. Do you experience headaches? yes no
If yes, daily 1-2/week 3-4/week occasionally
Where about your head are they located? _____
How long do they last? _____
What brings them on? _____
Can you take them away? yes no If yes, How? _____
13. Do you experience blurring of your vision? yes no
14. Do you experience dizziness? yes no
15. Do you experience ringing in the ears? yes no (Right Left)
16. Do you experience fullness (cotton) in the ears? yes no (Right Left)
17. Do you clench your teeth? yes no
18. Do you grind your teeth? yes no
19. Do you experience memory or concentration problems? yes no

E. Medical History

1. Do you have or have had problems with any of the following?
 Heart Blood Pressure (high or low) Blood Disorder Asthma
 Allergies Cancer Bowel Bladder Kidney Stomach
 Lungs Psychological Brain/Seizure Hepatitis HIV
 AIDS Arthritis Low Back Injury Whiplash Diabetes
 Work related injury Alcohol/Substance Abuse Other _____
2. Recent surgery? yes no
If yes, what kind ? and when? _____
3. List all medications you are taking:
- | <u>Name</u> | <u>Dosage</u> | <u>What is it for?</u> |
|-------------|---------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

4. Please check off all of the following that you have experienced in the last year:

- | | | |
|--|--|--|
| <input type="checkbox"/> hot palms/feet | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> depression | <input type="checkbox"/> indigestion | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> daytime sweats | <input type="checkbox"/> constipation | <input type="checkbox"/> frequent night urination |
| <input type="checkbox"/> low energy | <input type="checkbox"/> diarrhea | <input type="checkbox"/> urgency to urinate |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> increased frequency
to urinate |
| <input type="checkbox"/> general body heat | <input type="checkbox"/> bruising | <input type="checkbox"/> impotence |
| <input type="checkbox"/> general body coldness | <input type="checkbox"/> hemorrhage | <input type="checkbox"/> low sex drive |
| <input type="checkbox"/> excessive thirst | <input type="checkbox"/> worry | <input type="checkbox"/> low backache/weakness |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> obesity | <input type="checkbox"/> feel cold in the back |
| <input type="checkbox"/> angina | <input type="checkbox"/> sluggish after meals | <input type="checkbox"/> strong color/smell in urine |
| <input type="checkbox"/> anxiety/nervousness | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> prolapsed bladder/uterus | <input type="checkbox"/> menstrual disorders |
| <input type="checkbox"/> anemia | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> graying hair |
| <input type="checkbox"/> bitter taste in mouth | <input type="checkbox"/> gain in appetite | <input type="checkbox"/> menopause/hysterectomy |
| <input type="checkbox"/> cloudy mind | <input type="checkbox"/> weight loss | <input type="checkbox"/> pregnancies # _____ |
| <input type="checkbox"/> memory loss | <input type="checkbox"/> weight gain | <input type="checkbox"/> births # _____ |
| <input type="checkbox"/> night mares | <input type="checkbox"/> undigested food in stools | <input type="checkbox"/> pain/weak knees |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> lesions in/around mouth | <input type="checkbox"/> low thyroid |
| | <input type="checkbox"/> diabetes | <input type="checkbox"/> mental fatigue |
| | <input type="checkbox"/> swelling | <input type="checkbox"/> fractures – osteoporosis |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> headaches | |
| <input type="checkbox"/> cough | <input type="checkbox"/> stiff joints | |
| <input type="checkbox"/> asthma | <input type="checkbox"/> muscle cramps | |
| <input type="checkbox"/> phlegm in throat | <input type="checkbox"/> jaundice | |
| <input type="checkbox"/> sinus trouble | <input type="checkbox"/> PMS/period cramps | |
| <input type="checkbox"/> tightness in chest | <input type="checkbox"/> brittle nails | |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> restless sleep | |
| <input type="checkbox"/> allergies | <input type="checkbox"/> dry & itchy eyes | |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> lump in throat | |
| <input type="checkbox"/> weak/hoarse voice | <input type="checkbox"/> blurred vision | |
| | <input type="checkbox"/> heartburn | |
| | <input type="checkbox"/> irritability | |
| | <input type="checkbox"/> numbness in legs/arms | |

Of only the following, which is your favorite? Color? Taste?

- | | | | | |
|---------------------------------|---------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> red | <input type="checkbox"/> yellow | <input type="checkbox"/> white | <input type="checkbox"/> black | <input type="checkbox"/> green |
| <input type="checkbox"/> bitter | <input type="checkbox"/> sweet | <input type="checkbox"/> spicy | <input type="checkbox"/> salty | <input type="checkbox"/> sour |

I give consent to my therapist to complete an assessment and give treatment as indicated by my condition. Each therapeutic technique to be utilized will be explained in full by the attending physiotherapist/massage therapist. This consent shall remain in effect throughout the required period of therapy.

Signature of Patient

Date