## PATIENT QUESTIONNAIRE

**DATE :**_____

**NAME:** _____**DATE OF BIRTH (D/M/Y)** _____/____/_____

**ADDRESS:** _____**City**_____**Postal Code**_____

**HOME PHONE:** _____ **WORK PHONE:** _____ **OCCUPATION:** _____

**REFERRING DOCTOR:** _____ **FAMILY PHYSCIAN (if different):**_____

**Are you on a work restriction from your doctor?** **Yes** ☐ **No** ☐

**Do you have a pacemaker?** **Yes** ☐ **No** ☐

**For Women: Are you currently pregnant or think you might be pregnant** **Yes** ☐ **No** ☐

**Do you smoke?** **Yes** ☐ **No** ☐

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**Have you recently noted any of the following? Check all that apply:**

- ☐ **Fatigue**
- ☐ **Fever/chills/sweats**
- ☐ **Nausea/vomiting**
- ☐ **Weight loss/gain**
- ☐ **Difficulty maintaining balance while walking**
- ☐ **Numbness/tingling**
- ☐ **Weakness**
- ☐ **Dizziness/light-headedness**
- ☐ **Shortness of breath**
- ☐ **Heart burn or indigestion**
- ☐ **Change in appetite**
- ☐ **Changes in bowel or bladder function**
- ☐ **Numbness/tingling in saddle area (seat/buttock)**
- ☐ **Pain worse at night than during the day**
- ☐ **Fainting**
- ☐ **Cough**
- ☐ **Headaches**

**Additional Questions:**

**i) During the past month have you been feeling down, depressed or hopeless?** **Yes** ☐ **No** ☐

**ii) During the past month have you been bothered by having little interest or pleasure in activities?** **Yes** ☐ **No** ☐

**iii) Is there something with which you would like help?** **Yes** ☐ **No** ☐

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**PAST MEDICAL HISTORY**

**Have you ever been diagnosed with or told you have had?:**

- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **High blood pressure**
- ☐ **Stroke**
- ☐ **Heart problems**
- ☐ **Epilepsy**
- ☐ **Anaemia**
- ☐ **Blood clots**
- ☐ **Alcoholism**
- ☐ **Lung problems**
- ☐ **Asthma**
- ☐ **Tuberculosis**
- ☐ **Rheumatoid arthritis**
- ☐ **Other arthritic conditions**
- ☐ **Bladder/urinary tract infection**
- ☐ **Kidney problem/infection**
- ☐ **Sexually transmitted disease/HIV**
- ☐ **Pelvic inflammatory disease**
- ☐ **Thyroid problems**
- ☐ **Angina/chest pain**
- ☐ **Osteoporosis**
- ☐ **Ulcers**
- ☐ **Liver problems**
- ☐ **Surgery**
- ☐ **Allergies**
- ☐ **Other problems not mentioned here**

**ABOUT YOUR CURRENT PROBLEM**

**Where are your symptoms now? _____**

**When did they start? _____**

**What caused the present symptoms? _____**

**My symptoms are currently (Circle one): Getting better / About the same / Getting worse**

**What makes the symptoms worse? _____**

**What makes the symptoms better? _____**

**Have you received treatment for this problem before? Yes☐ No☐**

**If yes, what was the result? _____**

**Please list special tests performed for this problem (x-ray, MRI, labs, etc.)**

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**In the scale below please circle the number which best represents the severity of your pain. When answering these questions, think only of the pain you are experiencing in relation to the problem for which you are having treatment.**

**Circle 1 number for each of the 4 questions. On average, how bad has your pain been?**

| | No Pain | | | | | | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **In the morning over the past 2 days?** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **In the afternoon over the past 2 days?** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **In the evening over the past 2 days?** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **With activity over the past 2 days?** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

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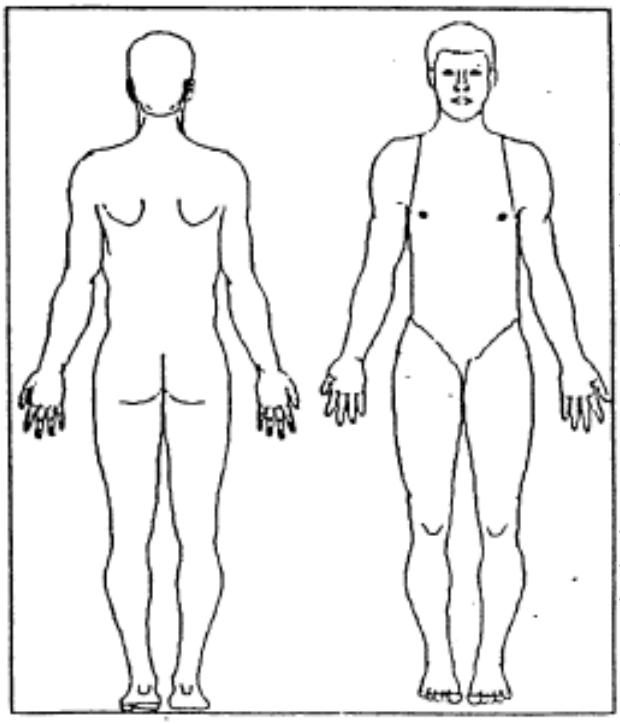

**Please mark the areas where you feel symptoms and try to describe them.**

_____

_____

_____

**My symptoms currently:**
**□ come and go**
**□ are constant**
**□ are constant but change with activity**

**Please list any medications you are currently taking._____**

_____

_____

_____

**Have you ever taken steroid medications for medical conditions?**

**Yes□ No□**