PhysioWell
HEALTH SOLUTIONS

PATIENT QUESTIONNAIRE

Full name: ____ Date: _________________

Date of Birth (MM / DD / YYYY): ____

Address: ____

City: _________________________________ Postal Code: _______________________

Home Phone: _________________________ Work Phone: _______________________

Cell: ___________________________ Email: __________________________________

Occupation: ____

Family Physician: ___________________________________

Referring Physician (if different): ________________________________

Do you have a pacemaker? Yes ____ No ____

Women, are you pregnant or thinking of becoming pregnant? Yes ____ No ____

Are you currently on a work restriction? Yes ____ No ____

Do you smoke? Yes ____ No ____

Have you been experiencing any of the following symptoms?

- ○ Dizziness
- ○ Headaches
- ○ Changes in bowel / bladder function
- ○ Saddle area numbness / tingling
- ○ Balance Difficulties
- ○ Fainting
- ○ Night Pain
- ○ Fatigue
- ○ Numbness / tingling
- ○ Shortness of Breath
- ○ Weight loss or gain
- ○ Loss of appetite
- ○ Fever / chills / night sweats
- ○ Weakness

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Have you ever been diagnosed with or have had the following?

- ○ Cancer
- ○ Diabetes
- ○ High Blood Pressure
- ○ Stroke
- ○ Heart Attack
- ○ Angina
- ○ Other Heart Conditions
- ○ Epilepsy
- ○ Blood Clots
- ○ Lung Problems
- ○ Arthritis
- ○ Rheumatoid Arthritis
- ○ Osteoporosis
- ○ Thyroid Condition
- ○ Bladder Problems
- ○ Allergies
- ○ Surgery (explain)
- ○ Other (explain)

Current Medications / Conditions Medications Treat:_________________________

____

____

Please describe your current symptoms:

Location of Pain: ____

When did symptoms start? ____

What caused present symptoms? ____

What makes it worse? ____

What helps to ease the pain? ____

Rate pain severity on a scale from 0 – 10 (10 being the worst pain) ________________

Have you had any imaging on this area (i.e. X-Ray, Ultrasound, MRI, CT Scan)?

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Are you currently being treated by another healthcare professional for this issue?

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