

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: _____

Emergency Contact Name: _____ Tel.: _____

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?

- | | |
|---|---|
| <input type="radio"/> Dizziness | <input type="radio"/> Fatigue |
| <input type="radio"/> Headaches | <input type="radio"/> Numbness / tingling |
| <input type="radio"/> Changes in bowel / bladder function | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Saddle area numbness / tingling | <input type="radio"/> Weight loss or gain |
| <input type="radio"/> Balance Difficulties | <input type="radio"/> Loss of appetite |
| <input type="radio"/> Fainting | <input type="radio"/> Fever / chills / night sweats |
| <input type="radio"/> Night Pain | <input type="radio"/> Weakness |

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

- | | | |
|---|--|---|
| <input type="radio"/> Cancer | <input type="radio"/> Other Heart Conditions | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Diabetes | <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid Condition |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Blood Clots | <input type="radio"/> Bladder Problems |
| <input type="radio"/> Stroke | <input type="radio"/> Lung Problems | <input type="radio"/> Allergies |
| <input type="radio"/> Heart Attack | <input type="radio"/> Arthritis | <input type="radio"/> Surgery (explain) |
| <input type="radio"/> Angina | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> 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)?

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