HealthWorks
Physiotherapy Massage Therapy Acupuncture

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

ADMISSIONS QUESTIONNAIRE

email:_____

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	□ yes □ no	Helped?	□ yes □ no
Chiropractor	□ yes □ no		□ yes □ no
Massage Therapist	□ yes □ no		□ yes □ no
Acupuncturist	□ yes □ no		□ yes □ no
Other _____	□ yes □ no		□ yes □ 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: _____
Name of supervisor: _____ Phone #: _____

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

   0 ◄——————————————————► 10

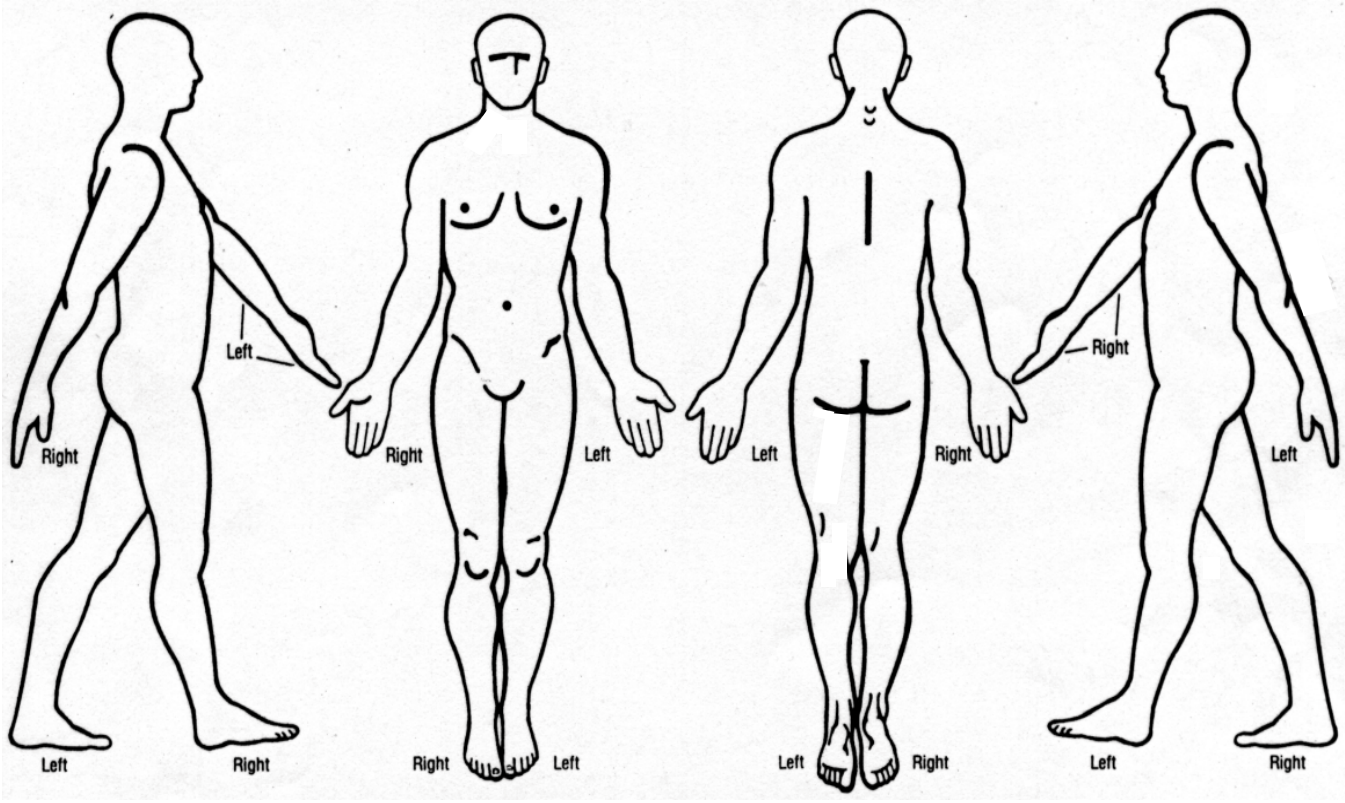
2. What does you pain feel like?
   □ dull ache □ sharp line □ throbbing □ tight
   □ burning □ twinge □ stabbing □ other _____

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:

Name	Dosage	What is it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

□ hot palms/feet
□ depression
□ daytime sweats
□ low energy
□ dizziness
□ general body heat
□ general body coldness
□ excessive thirst
□ heart disease
□ angina
□ anxiety/nervousness
□ insomnia
□ anemia
□ bitter taste in mouth
□ cloudy mind
□ memory loss
□ night mares
□ heart palpitations

□ fatigue
□ cough
□ asthma
□ phlegm in throat
□ sinus trouble
□ tightness in chest
□ frequent colds/flu
□ allergies
□ shortness of breath
□ weak/hoarse voice

□ bloating/gas
□ indigestion
□ constipation
□ diarrhea
□ nausea/vomiting
□ bruising
□ hemorrhage
□ worry
□ obesity
□ sluggish after meals
□ hemorrhoids
□ prolapsed bladder/uterus
□ loss of appetite
□ gain in appetite
□ weight loss
□ weight gain
□ undigested food in stools
□ lesions in/around mouth
□ diabetes
□ swelling

□ headaches
□ stiff joints
□ muscle cramps
□ jaundice
□ PMS/period cramps
□ brittle nails
□ restless sleep
□ dry & itchy eyes
□ lump in throat
□ blurred vision
□ heartburn
□ irritability
□ numbness in legs/arms

□ night sweats
□ incontinence
□ frequent night urination
□ urgency to urinate
□ increased frequency to urinate
□ impotence
□ low sex drive
□ low backache/weakness
□ feel cold in the back
□ strong color/smell in urine
□ ringing in ears
□ menstrual disorders
□ graying hair
□ menopause/hysterectomy
□ pregnancies # _____
□ births # _____
□ pain/weak knees
□ low thyroid
□ mental fatigue
□ fractures – osteoporosis

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

□ red □ yellow □ white □ black □ green
□ bitter □ sweet □ spicy □ salty □ 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