



# HealthWorks

Physiotherapy Massage Therapy Acupuncture

Medical Office Wing  
1440 – 14<sup>th</sup> 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	<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

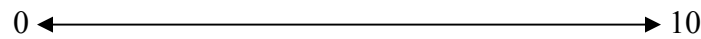
7. Name of employer: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name of supervisor: \_\_\_\_\_

**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

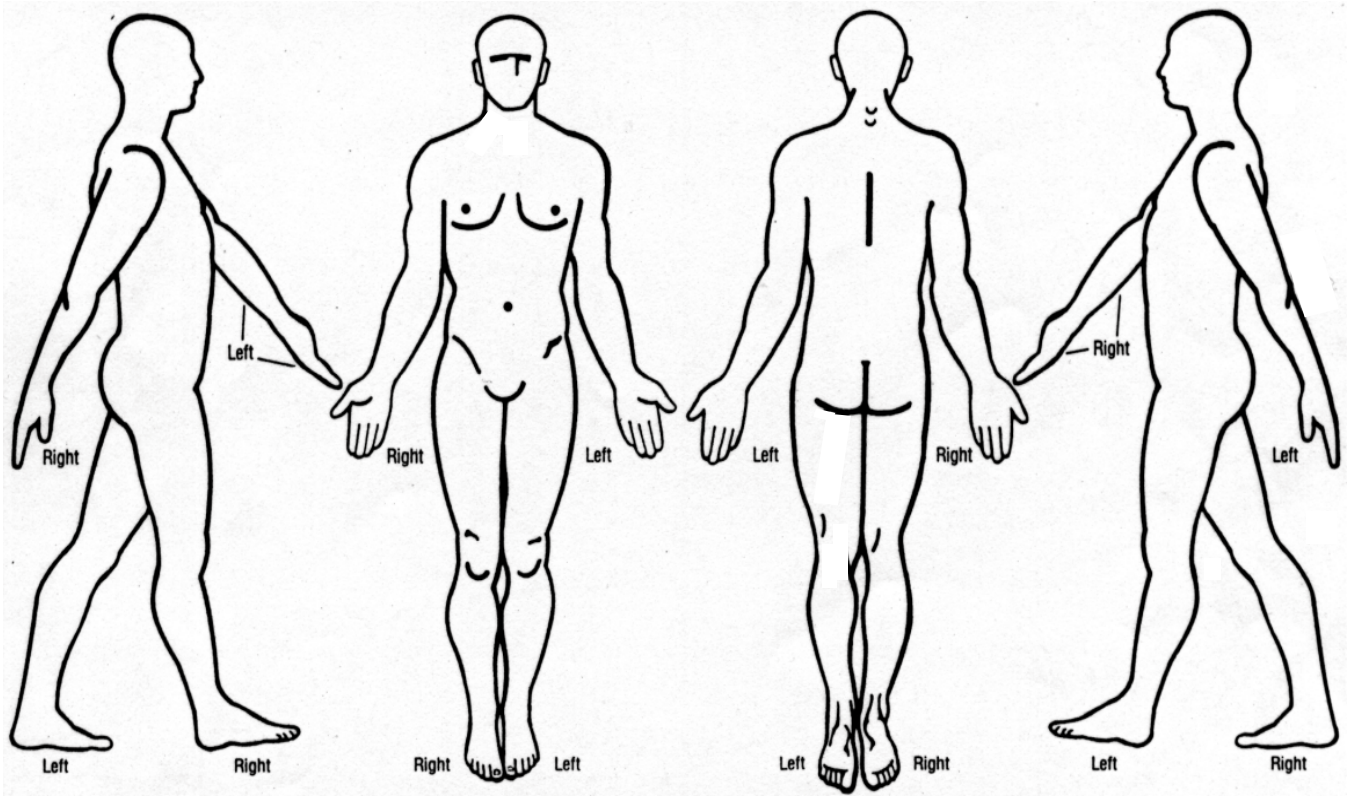


2. What does your pain feel like?  
 dull ache     sharp line     throbbing     tight  
 burning     twinge     stabbing     other \_\_\_\_\_

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<br>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