

Health Questionnaire

Name _____ **Date** _____

Date of Birth _____ (Month/Day/Year)

Home Address _____

City _____ **Postal Code** _____

Home Phone _____ **Work Phone** _____ **Work Phone** _____

Health Card Number _____ **Version Code** _____

Emergency Contacts _____

Family Physician _____ **Phone** _____

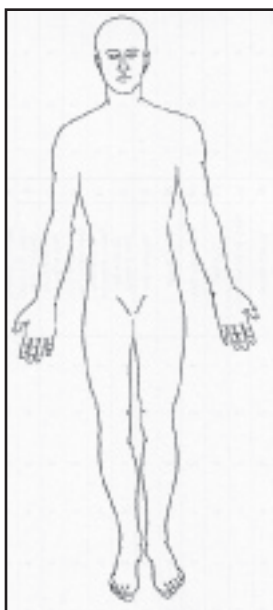
Dentist _____ **Phone** _____

What is your native language? _____ **Are you fluent in English?** Yes No

A.) CURRENT SYMPTOMS

1. Do you have any bone/joint or soft tissue symptoms?

On the drawings below please indicate where you are experiencing symptoms by drawing the appropriate symbol(s) on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.



Tingling 0 0 0
0 0 0

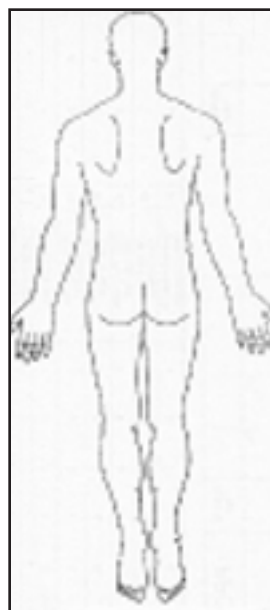
Burning XXX
XXX

Numbness ===
===

Sharp Pain ///
///

Dull Pain vv
vv

Stiffness ###
###



Doctors Only



Rate your pain (10- worst imaginable; 0-no pain)

Most of the time _____ At best _____ At worst _____

How long have you had the pain(s)? _____

Anything associated with the onset? _____

Please list aggravating factors? _____

2. Do you have any skin problems? **Yes** **No**

3. Do you have any nervous systems disorders?
(e.g. epilepsy, balance problem, dizziness) **Yes** **No**

4. Do you have any psychiatric / psychological problems? **Yes** **No**

Describe _____

Have you had two years or more in your life when you
felt depressed or sad most days even if you felt okay
sometimes? **Yes** **No**

Have you felt depressed or sad much of the time in the
past year? **Yes** **No**

How much of the time in the past week did you feel
depressed? **Less than one day**
 Less than two days
 Three or four days
 More than four days

5. Do you have any problems with your eyes/ears/nose/
throat?

6. Do you have any respiratory problems? (e.g. asthma,
bronchitis, cough)

7. Do you have any digestive system problems? (e.g.
ulcer, irritable) **Yes** **No**

Doctors Only



8. Do you have any urinary system problems? (e.g. recurrent infection, prostate, kidney, bladder problems)

Yes **No**

9. Do you have any problems with sexual function?

Yes **No**

10. Do you have any chest pain or cardiovascular (heart) problems?

Yes **No**

If yes, please circle:

- High Cholesterol
- High Blood Pressure
- Heart Attack
- Angina
- Heart Surgery
- Diabetes

Questions for Women

1. Are you pregnant or planning a pregnancy?

Yes **No**

B. MEDICAL HISTORY

1. List current, previous or ongoing medical problems / treatment

2. Surgeries (reason / date)

Doctors Only



3. Hospitalizations (reason / date)

4. Current Medications

Over the counter medications / supplements (vitamins etc.)

5. Injuries / Trauma / Accidents (date / injuries)

Fractures / broken bones _____

6. Allergies to drugs / medications?

Other allergies _____

Doctors Only



7. Immunizations

- Do you get the annual flu shot? **Yes** **No**
- Are your immunizations up to date? **Yes** **No**
- Tetanus / Diptheria / Polio **Yes** **No**
- Hep A **Yes** **No**
- Hep B **Yes** **No**
- Pneumovax **Yes** **No**
- Other _____

Doctors Only

C. SOCIAL HISTORY

Who lives with you? _____

Do your symptoms affect your ability to do normal activities at home? **Yes** **No**

If yes, what activities? _____

D. OCCUPATIONAL HISTORY

1. Do you work outside your house? **Yes** **No**

2. What type of work do you do? _____

3. Do your symptoms affect your ability to do your work activities? **Yes** **No**

If yes, what activities? _____

4. Have you ever had a work related accident resulting in time away from work? **Yes** **No**

If yes, when? _____

5. Have you ever submitted a claim to the Worker's Compensation Board WSIB or the C.S.S.T. (Quebec)? **Yes** **No**

If yes, when? _____



6. Have you ever required a medical restriction or accomodation at work?

Yes **No**

If yes, when? _____

7. Are you receiving or have you ever received a pension?

Yes **No**

If yes, for what reason? _____

Doctors Only

E. LIFESTYLE HABITS

1. Exercise

How often do you exercise per week?

- Greater than 4 times Light
- Daily Moderate
- 2-3 or more times / week Hard
- Rarely or never

2. Smoking

Have you ever smoked?

Yes **No**

If yes, when? _____

How many years? _____

How much per day, on average? _____

When did you stop? _____

3. Alcohol Use

Do you drink alcohol?

Yes **No**

How much per week? _____



During the last 12 months have you...

Felt you should cut down on your drinking?

Felt bad or guilty about your drinking?

Been annoyed at people criticizing your drinking?

Had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

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4. Stress

How would you measure your current stress level?

High

Moderate

Low

5. Sleep

What time do you go to bed? _____

How long does it take you to fall asleep? _____

How many times do you wake at night? _____

Why? _____

How many hours per night? _____

Do you wake rested?

Yes

No

6. Diet

Please rate your diet

Good

Fair

Poor



F. HEALTH GOALS

What are your health goals?



I, the undersigned, declare that the above information is correct and has been submitted to the best of my knowledge.

Signature

Date

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