# Injury Date: MMDDYYYY

Nature of injury: MVA/WSIB/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# General History C P

Trauma □ □

Fever/Chills □ □

Allergies(MB) □ □

Malaise/Fatigue(MB) □ □

Weakness(MB) □ □

Medications (List Below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries (List Below – INCLUDE ANY DENTAL WORK/AMALGUM FILLINGS) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History C P**

Diabetes □ □

Thyroid Disease □ □

Tuberculosis □ □

Kidney Disease □ □

↑ or ↓Blood Pressure □ □

Heart Disease/Stroke □ □ Musculoskeletal disease □ □

Cancer □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Endocrine System C P

 Heat/Cold Intolerance □ □

Thyroid Problems(MB) □ □

Diabetes(MB) □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Eye/Ear/Nose/Throat C P

Visual Problems □ □

Pain in eyes □ □

Difficulty Hearing □ □

Ringing in Ears □ □

Dizziness □ □

Ear Pain □ □

Ear Discharge □ □

Change in Smell □ □

Sinusitis(MB) □ □

Hoarseness □ □

Difficulty Swallowing □ □

Change in Taste □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Genito-Urinary System C P

Pain on Urination □ □

Change in Urine Colour □ □

Difficulty Starting Stream □ □

Difficulty Holding Urine □ □

Urinary Tract Infection(MB) □ □

Kidney Disease □ □

Flank Pain □ □

Prostate Problem □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Gastrointestinal System C P

Peptic Ulcer(MB) □ □

Nausea/Vomiting(MB) □ □

Indigestion/heartburn(MB) □ □

Abdominal Pain(MB) □ □

Abdominal Swelling □ □

Constipation(MB) □ □

Diarrhea(MB) □ □

Hemorrhoids(MB) □ □

Hernia □ □

Gall Bladder Disease □ □

Liver Disease □ □

Pancreatitis □ □

Alcohol Intake □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Respiratory System C P

Difficulty Breathing □ □

Cough □ □

Wheezing/Asthma(MB) □ □

Tuberculosis exposure □ □

Pneumonia □ □

Lung Infections □ □

Emphysema □ □

Do you smoke □ yes □ no \_Packs/day

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Cardiovascular System C P

Shortness of Breath □ □

Chest Discomfort/Pain □ □

Arm Discomfort/Pain □ □

Palpitations □ □

Edema/Swelling □ □

Fainting □ □

Sudden calf pain when walking □ □

Heart Disease □ □

High/Low blood pressure □ □

Rheumatic Fever □ □

Do you have a pacemaker? Yes□/No□

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Skin/Hair/Nails C P

# Change in Skin Temp. □ □

Change in Skin Texture □ □

Skin Dryness/Wetness □ □

Rashes/Itching/Sores(MB) □ □

Skin Growths □ □

Mole Changes □ □

Skin Cancer □ □

Change in Nail Shape/Colour □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE PATIENTS ONLY**

□ Onset of last period

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Are you pregnant: Yes/No

Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Birth control method Indicate(MB):

# Neurological System C P

Headaches/Migraines(MB) □ □

Epileptic Seizures □ □

Tics/Spasms □ □

Dizziness/Fainting □ □

Sensation Disturbances □ □

Unusual Weakness □ □

Head Trauma □ □

Stroke □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Musculoskeletal System C P

Joint Stiffness □ □

Joint Pain □ □

Joint Swelling □ □

Muscle Cramps □ □

Muscle Weakness □ □

Muscle Wasting □ □

Neck Pain □ □

Mid Back Pain □ □

Low Back Pain □ □

Sacroiliac Pain □ □

Tailbone Pain □ □

Arm Problem □ □

Leg Problem □ □

Fractures/Dislocation □ □

Sprains/Strains □ □

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY OTHER DIAGNOSED HEALTH CONDITIONS?**

Herpes □ □

HIV / AIDS □ □

Tuberculosis (TB) □ □

Hepatitis A/B/C □ □

*Are you currently receiving treatment from another health care professional?*

Yes/No; If yes for what \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel that you currently have significant stress in your life?

□ Yes □ No

I am **optimistic** that my present problem will improve. *(Please circle one)*

 *1 = strongly disagree*

*2 = disagree*

*3 = no opinion*

*4 = a*gree

5 = strongly agree

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_

**ProviderSignature**: \_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*IF NOTHING APPLIES PLEASE SIGN THE ABOVE ACKNOWLEDGING YOU ARE IN GOOD HEALTH.\*\*\*\*\*\*\*\*\*