physiotherapykingston
spinalrehabcentre

By Law We Must Obtain This Important Information For Our Records

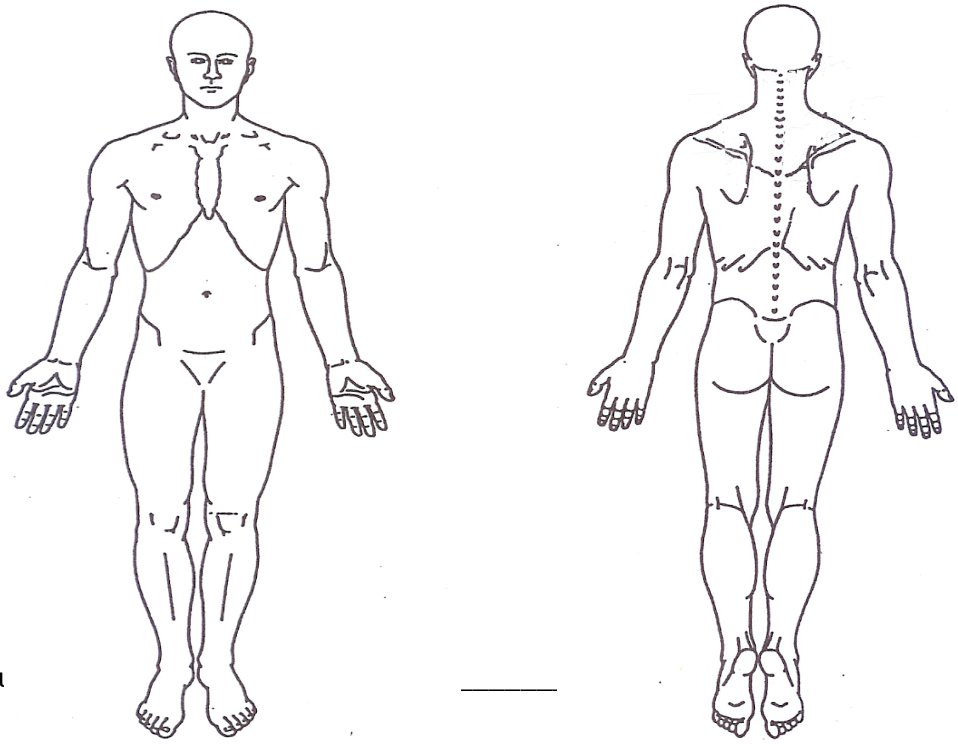
DATE: _____

Name:

_____

Family Doctor: _____ Referring Doctor: _____

Please draw on the diagram where you have your symptoms:



Present/previou _____

Please explain

_____
_____
_____
_____
_____
_____
_____
_

Do you have any other medical problems?

_____

_____

List Medications: _____

_____

List any surgeries?_____

List any x-rays, MRI, CT scans, etc? If so please explain:_____

Did you have any other injuries ? Y ( ) N ( ) If so please explain:_____

_____

_____

If no, when did your pain start: _____

Does your pain affect your job or lifestyle? Y ( ) N ( ) If so, how: _____

_____

your pain affect your sleep Y ( ) N ( )

Is your pain better in the ( ) morning ( ) afternoon ( ) evening ( ) night

Is your pain worst ( ) morning ( ) afternoon ( ) evening ( ) night

Do you have ( ) pins/needles ( ) tingling ( ) numbness**:** in the ( ) arms ( ) hands ( ) legs ( ) feet

Have you had recent changes in your bowel or bladder, i.e. incontinent? Y ( ) N ( )

Do you have headaches? Y ( ) N ( ) If so, where are they located? _____

When are the headaches worst: _____

Do you have bouts of dizziness? Y ( ) N ( )

What hobbies/activities do you participate in? _____

_____

What are your goals for therapy?_____

_____

MOTOR VEHICLE ACCIDENTS:

Date of accident: (MM/DD/YY)_____

Vehicle you were in: Make_____Year_____Damage $_____

Vehicle that hit you: Make_____Year_____Damage $_____

Speed you were going: _____Speed other vehicle was going: _____

Explain how accident occurred: _____

_____

_____

How did you hear about our clinic? _____

Do you have extended insurance coverage? _____

Observation	Palpation
ROM Active: Passive: Resisted Testing Neurological SLR: Slump: DTR: Myotomes: Dermatomes: Other:	Special Tests Analysis Plan