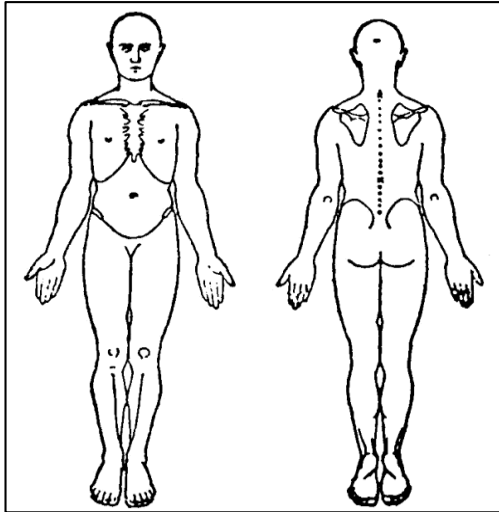


# Patient Questionnaire Physiotherapy

Please fill out the questionnaire below to the best of your ability. If a question does not relate to you, leave it blank and the therapist will review it with you during your assessment.

NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_



Please show your symptoms on the diagram to the *left* (Sore/Stiff with an X, Tingling/Numbness with an O):

Is your injury interfering with your daily activities?  Yes  No

Please indicate below which goals you hope to address with treatment:

- Reduce soreness/swelling  Diagnosis  Return to work  
 Improve motion  Exercise advice  Return to sport/daily activity

How did your injury occur? \_\_\_\_\_

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

When did your symptoms occur? _____	Are you Experiencing? (Check those that apply) <input type="checkbox"/> Headaches <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Double Vision <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Other	
Describe your symptoms: <input type="checkbox"/> Dull Ache <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Throbbing <input type="checkbox"/> Other _____	Are your Symptoms? <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	Please rate your pain on a scale 0-10, 10 being worst pain imaginable. Worst _____ Best _____ Currently _____
What aggravates your symptoms: <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Other	What eases your symptoms? <input type="checkbox"/> Hot Shower <input type="checkbox"/> Lying down <input type="checkbox"/> Medication <input type="checkbox"/> Heat <input type="checkbox"/> Ice	When you cough or sneeze, your symptoms are: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No different
Do your symptoms wake you up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the morning do you feel: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Different	In the evening do you feel: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No different

Have you had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Have you had any special test/procedures? <input type="checkbox"/> X-Ray <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Bone Scan <input type="checkbox"/> Blood Test <input type="checkbox"/> Ultrasound <input type="checkbox"/> None <input type="checkbox"/> Other _____
Are you taking any medication? <input type="checkbox"/> Blood Thinners <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Pain <input type="checkbox"/> Muscle Relaxant <input type="checkbox"/> Anti-depressant <input type="checkbox"/> Steroids Others _____	Have you seen any other health professional regarding this injury? <input type="checkbox"/> Doctor/Physician <input type="checkbox"/> Surgeon/Specialist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Massage <input type="checkbox"/> Other _____





## Client Privacy Policy and Consent Form

The Panther Sports Medicine and Rehabilitation Centres are committed to controlling and protecting the collection, use and disclosure of the personal information provided by its patients. Our policy is guided by the Canadian Standards Association Model Code and synthesizes relevant material from the Protection of Personal Information Protection and Electronic Documents Act (PIPEDA), Personal Information Protection Act (PIPA), and Health Information Act (HIA). A complete copy of the Innovative Health Group Inc. Privacy Policy is available on the Panther Sports Medicine website at: [www.PantherSportsMedicine.com](http://www.PantherSportsMedicine.com).

I, \_\_\_\_\_, the patient/parent/guardian, hereby agree to the following:

**Authorization for Treatment** – Consent for treatment at Panther Sports Medicine.

**Release of Health Information** – Authorize Panther Sports Medicine to provide medical information (status and progress) to my medical practitioner, insurance company, WCB, employer, Lawyer or their representative as needed for my treatment episode. I understand and authorize that this information may be exchanged electronically on my behalf.

**Fees for Treatment** – To pay outstanding fees incurred for therapy.

**Benefit Assignment and Consent** - I hereby assign benefits payable for my eligible claims to Panther Sports Medicine for submitting my claims electronically to my group benefits plan. I authorize the insurer to issue payment directly to Panther Sports Medicine. I understand the insurer is under no obligation to accept this assignment. I agree that this assignment will apply to all eligible claims submitted electronically by the provider. If I am a dependent I confirm that I am authorized by the plan member to assign benefit of payments to Panther Sports Medicine. In the event that claims are denied I understand that I remain responsible for payment to the provider for any services rendered and/or supplies provided.

Patient Signature: \_\_\_\_\_ (signature of parent or legal guardian required if patient is less than 18 years old)

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

*To reschedule an appointment, we require 24 hours notice. Otherwise, a late cancellation or no show fee may be charged. For your convenience, an answering machine will take your call after hours. Please be courteous so other clients can schedule for this appointment.*

