Dr. Alison Coutts, DC, CMRP

238 Wellington St. E. Ste. 210
Aurora, ON L4G 1J5

39 Alvin Ave. Ste. 2
Toronto, ON M4T 2A7

Dear New Client,
Please complete the following questionnaire as fully and carefully as possible. Your answers will help to process your file, determine the nature of your complaint and decide how best to assist you. This information will remain strictly confidential.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ M / F
(dd/mm/yyyy)

Mailing Address: _____
Street Number & Name City Postal Code

Home Phone: _____ Business Phone:_____

Cell Phone:_____ Email:_____

Family Doctors Name: _____ Phone Number:_____

Occupation: _____

Emergency Contact: _____ Relation:_____ Phone :_____

How did you hear of Dr. Coutts? _____

CURRENT HEALTH STATUS

What are you seeking treatment for? _____

Have you had this injury/condition before? Yes / No If yes, when:_____

Did you seek therapy for it? Yes / No If yes, what kind:_____

Was this a motor vehicle accident (MVA) or a workplace injury? Yes / No

How long has the condition been bothering you? _____

Have you had any imaging for this condition (X-ray, CT scan, MRI)? Yes / No

If yes, when and where? _____

Are there any other conditions you would like to discuss? _____

Please list any **medications or supplements** you are currently taking and the reason for taking them:

_____

_____

_____

Please list any previous **surgeries, hospitalizations, fractures, or accidents/traumas** (include year):

_____

_____

_____

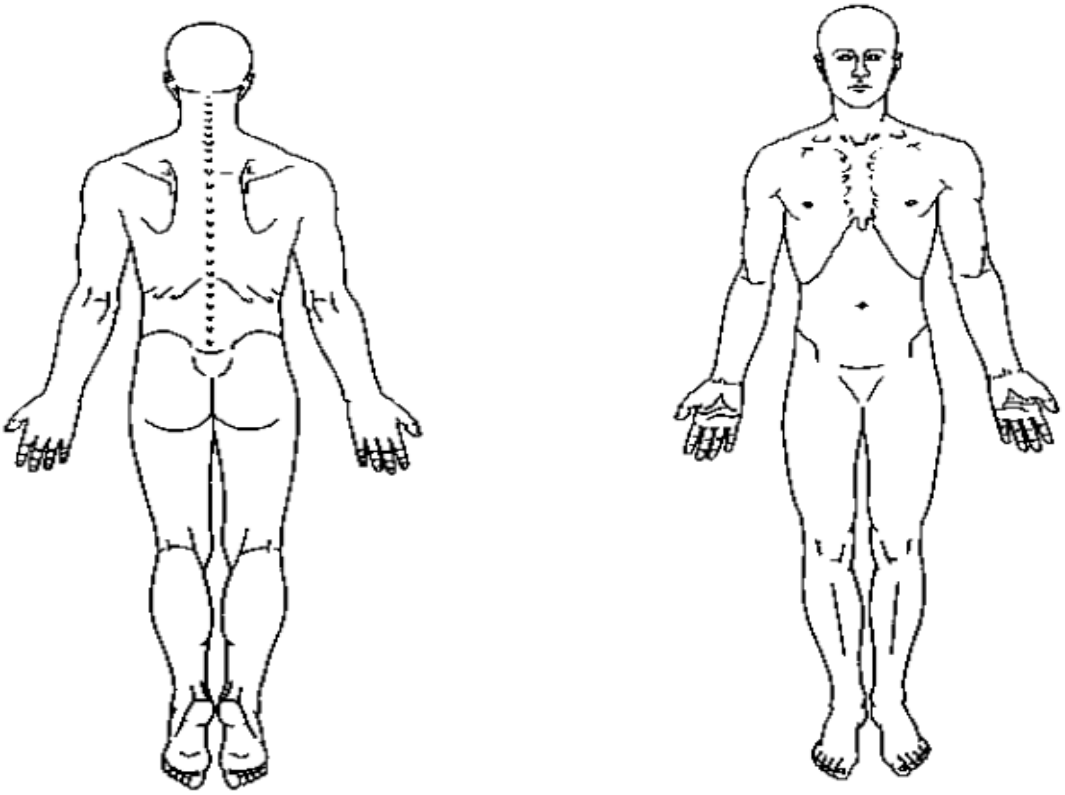
Name: _____ **Date: _____**

On the diagram provided below please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

SYMBOLS:

Numbness zzzzz	Pins & Needles …….	Dull & Aching //////////	Other *****
Burning xxxxxxx	Sharp & Stabbing oooooo	Stiff and Tight +++++++	_____

L R R L



What movements/activities are especially aggravating to your pain? _____

What movements/activities make you feel more comfortable? _____

Is your pain getting better? worse? staying relatively constant?_____

Rate the following by circling a number:

Rate your pain **right now**: None – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – Worst ever felt

Rate your **typical/average** pain: None – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – Worst ever felt

Rate your pain **at its best**: None – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – Worst ever felt

Rate your pain **at its worst**: None – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – Worst ever felt

Name: _____ **Date:** _____

Please indicate which of the following you are currently experiencing or have experienced in the past by writing **C (for current)** or **P (for past)** where applicable.

CARDIOVASCULAR
__ Heart Attack
__ Stroke / TIA
__ High Blood Pressure
__ Low Blood Pressure
__ Circulatory Disorders
__ Varicose Veins
__ Pacemaker
__ Phlebitis
__ Heart Disease
__ Chronic Congestive Heart Failure
__ Myocardial Infarction

SKIN
__ Bruise Easily
__ Eczema / Psoriasis
__ Rash
__ Cold Sores / Warts
__ Herpes
__ Athlete's Foot
__ Loss of Sensation
__ Other_____

RESPIRATORY
__ Emphysema
__ Asthma
__ Chronic Cough
__ Bronchitis
__ Breathing Difficulty
__ Lung Disorder

HEAD & NECK
__ Headache
__ Migraine
__ Visual Disturbances
__ Earaches
__ Hearing Problems
__ Teeth / Jaw Pain
__ Locked Jaw
__ Sinus Pain
__ Injury
__ Dizziness / Vertigo
__ Tinnitus / Ear Ringing

NEUROLOGICAL
__ Epilepsy
__ Multiple Sclerosis
__ Loss of Sensation
__ Neuritis
__ Other _____

SOFT TISSUE & JOINTS
__ Neck
__ Shoulder
__ Arm / Elbow
__ Chest
__ Abdomen
__ Upper Back
__ Mid Back
__ Lower Back
__ Hip
__ Leg
__ Knee
__ Ankle

DIGESTIVE & URINARY
__ Chronic Abdominal Pain
__ Prolonged Constipation
__ Diarrhea
__ Frequent Urination
__ Irritable Bowel Syndrome
__ Ulcerative Colitis/Crones
__ Pelvic Inflammatory Disease
__ Gastritis
__ Liver / Gall Bladder
__ Kidney / Bladder Disease

GENITOURINARY
__ Hemorrhoids
__ Prostate Problems
__ Erectile Dysfunction
__ Hernias
__ Menstrual Problems
__ Menopausal Problems
__ Endometriosis
__ Previous C-Section
__ Poly Cystic Ovarian Syndrome
__ Incontinence

OTHER
__ Allergies
__ Arthritis
__ Cancer
__ Carpal Tunnel Syndrome
__ Chronic Fatigue Syndrome
__ Diabetes
__ Inflammatory Arthritis
__ Fibromyalgia
__ Shingles
__ HIV / AIDS
__ Hemophilia
__ Hepatitis
__ Insomnia
__ Osteoporosis
__ Scoliosis
__ Tuberculosis
__ Fainting
Other Conditions Not Listed Above:

INJURIES
__ Muscle Strain
__ Ligament Sprain
__ Fracture
__ Whiplash
__ Herniated Disc
__ Other:_____

SURGICAL IMPLANTS
__ Pins
__ Plates
__ Rods
__ Artificial joints:
__ Hernia mesh reinforcements
__ Bladder mesh sling
__ Breast Implants
__ Dental Implants
__ Other: _____

Has anyone in your **family** had any of the following conditions (please specify whom):

Heart disease _____ High blood pressure _____

Cancer _____ Diabetes _____

Stroke _____ Inflammatory Arthritis _____

Other _____

Please indicate how often you take part in these activities in an average week:

Exercise (type) _____ days/wk____ Consume Alcohol_____ drinks/wk___

Consume Caffeine_____ drinks/wk___ Smoking (please circle past/present) packs/day___

If you previously smoked please indicate how long you have quit for? _____

Do you wear orthotics Yes / No If yes, how long have you had this pair? _____