

Dr. Alison Coutts, DC, CMRP

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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
Burning xxxxxxx

Pins & Needles
Sharp & Stabbing oooooo

Dull & Aching ///////////////
Stiff and Tight ++++++

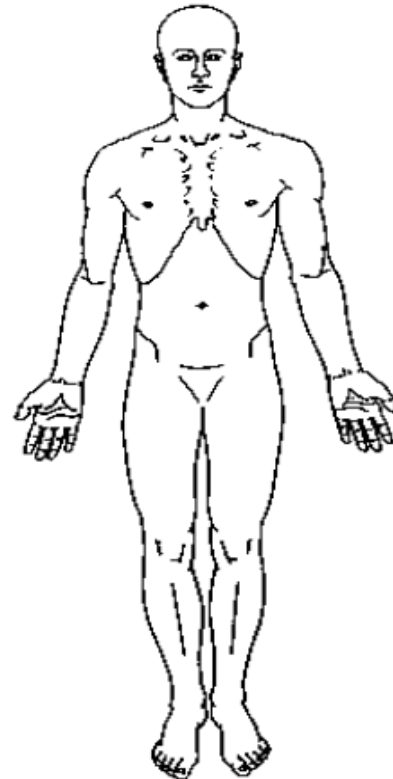
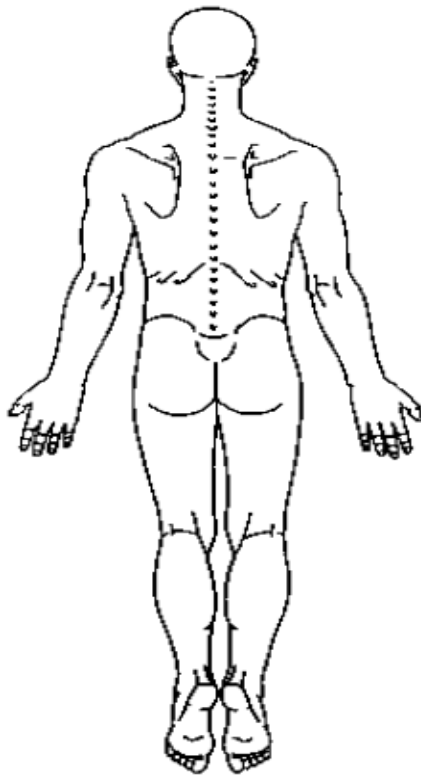
Other *****

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.

<p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Circulatory Disorders <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Pacemaker <input type="checkbox"/> Phlebitis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Myocardial Infarction</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Lung Disorder</p>	<p>NEUROLOGICAL</p> <p><input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Neuritis <input type="checkbox"/> Other _____</p>	<p>DIGESTIVE & URINARY</p> <p><input type="checkbox"/> Chronic Abdominal Pain <input type="checkbox"/> Prolonged Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcerative Colitis/Crones <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Gastritis <input type="checkbox"/> Liver / Gall Bladder <input type="checkbox"/> Kidney / Bladder Disease</p>
<p>SKIN</p> <p><input type="checkbox"/> Bruise Easily <input type="checkbox"/> Eczema / Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Cold Sores / Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Other _____</p>	<p>HEAD & NECK</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Earaches <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Teeth / Jaw Pain <input type="checkbox"/> Locked Jaw <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Injury <input type="checkbox"/> Dizziness / Vertigo <input type="checkbox"/> Tinnitus / Ear Ringing</p>	<p>SOFT TISSUE & JOINTS</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm / Elbow <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back</p> <p><input type="checkbox"/> Hip <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Ankle</p>	<p>GENITOURINARY</p> <p><input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Hernias <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Menopausal Problems <input type="checkbox"/> Endometriosis <input type="checkbox"/> Previous C-Section <input type="checkbox"/> Poly Cystic Ovarian Syndrome <input type="checkbox"/> Incontinence</p>
<p>OTHER</p> <p><input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Diabetes <input type="checkbox"/> Inflammatory Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Shingles Other Conditions Not Listed Above:</p>		<p>INJURIES</p> <p><input type="checkbox"/> Muscle Strain <input type="checkbox"/> Ligament Sprain <input type="checkbox"/> Fracture <input type="checkbox"/> Whiplash <input type="checkbox"/> Herniated Disc <input type="checkbox"/> Other: _____</p>	<p>SURGICAL IMPLANTS</p> <p><input type="checkbox"/> Pins <input type="checkbox"/> Plates <input type="checkbox"/> Rods <input type="checkbox"/> Artificial joints: <input type="checkbox"/> Hernia mesh reinforcements <input type="checkbox"/> Bladder mesh sling <input type="checkbox"/> Breast Implants <input type="checkbox"/> Dental Implants <input type="checkbox"/> Other: _____</p>

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? _____