Rehab and Wellbeing Centre at Mount Sinai
600 University Ave., Room 1181
Toronto, ON M5G 1X5
t (416) 619-5546 f (416)619-5548

Multi-Disciplinary Health Questionnaire

Patient Information

Last Name	First Name	Initial	Title: Miss ☐ Ms ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Rev
Address:		Apt. #	Date of Birth (MM/DD/YYYY)
City:	Prov.	Postal Code	Health Card #:
Email:		Occupation:	
Please check off preferred contact. Home Phone: ☐	Cell Phone ☐	Business Phone ☐	Ext. #:
In case of emergency, contact person:		**Emergency Contact Phone:**	
Primary Care Physician Name, Address, and Number:		Who Referred you to our centre:	
Approximate Foot Size:	Do you have Extended Insurance:	HGT: WGT:	

Present reason for consulting the office

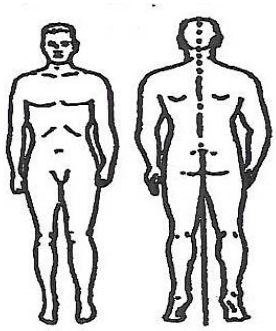
Current/Previous Therapies

Please check off any of the following care you are currently receiving or have received in the past;

☐ Chiropractic ☐ Physiotherapy ☐ Foot Care ☐ Massage Therapy ☐ Acupuncture ☐ Personal Training/Kinesiology ☐ Other

If yes, for what? _____

What is your major complaint? (Label the diagram below with an "X")



Date of Initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

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Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke / CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above?
☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above?
☐ Yes ☐ No

Infection
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Head / Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies / hypersensitivity to what?_____ type of reaction:_____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

is there a family history of arthritis?
☐ Yes ☐ No

Women
- ☐ pregnant, due: _____
- gynecological conditions, what? _____

Overall, how is your general health?
_____

Do you have any other medical conditions?
(e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
☐ Yes ☐ No
what?_____

Do you have any internal pins wires, artificial joints or special equipment?
☐ Yes ☐ No
what?_____

where?_____

Previous Surgeries (List all previous surgical operations and years)

Surgery	Date Surgery Performed
1.	
2.	
3.	
4.	
5.	

Medications and Supplements (List all prescription medications and supplements)

Medication or Supplement Name	Dosage, Frequency , Date Started and Condition it Treats
1.	
2.	
3.	
4.	
5.	

Have you been in an auto accident?
☐ Yes ☐ No

☐ Past Year
☐ Past 5 years
☐ Over 5 years
☐ Never

Describe _____ _____ _____

Have you had any other personal injury or accident?
☐ Yes ☐ No

☐ Past Year
☐ Past 5 years
☐ Over 5 years
☐ Never

Describe _____ _____ _____

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Chiropractic, Massage Therapy, Physiotherapy, Acupuncture, Podiatry, Chiropody and Kinesiology **MAY** be covered by your extended health care plans. Please check with your extended health care plan administrator to see if your treatment is covered.

You are required to pay for each treatment at the time of your visit. Payment may be made by cash, debit, Visa, Mastercard or Amex. Fees are subject to change without notice.

If you are going to be late for your appointment please contact us as soon as possible. We require **24 hours notification** for cancelled or rescheduled appointments. A late cancellation or no show will be charged for the full fee of the appointment.

All information obtained for treatment or diagnosis is confidential except as required or allowed by law or except to facilitate diagnosis/assessment or treatment. You will be asked to provide written authorization for release of any information.

Patient's Statement of Agreement:

I verify that I have read and understood the above and agree to follow the terms and conditions outlined.

Signed: _____ Date: _____

Patient's Name (please print): _____

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Consultation Consent Form

All patients should be aware that Rehab and Wellbeing Centre may occasionally share with other health professionals, your employer or workplace representative, or the adjudicators/adjusters assigned to your insurance claim (if applicable) information about your functional abilities and limitations and any other health information collected during your visits to the Centre for the purposes of:

- Treating and caring for you;
- Obtaining payment for your treatment and care (from OHIP, your private insurer or others); and/or
- Assisting with the processing of your application for insurance benefits.

In keeping with our policy of obtaining your consent before speaking to anyone on your behalf, we ask that you read and sign the following:

I, _____, hereby give my consent to Rehab and Wellbeing
(print name)

Centre at Mount Sinai to disclose my health information for the above purposes. Every effort will be made to ensure that my privacy will be respected at all times.