Rehab & Wellbeing Centre
Sinai Health System

Rehab and Wellbeing Centre Sinai Health System
600 University Ave., 20th Floor, Room 450
Toronto, ON M5G 1X5
t (416) 619-5546 f (416) 619-5548

Multi-Disciplinary Health Questionnaire

Patient Information

Last Name	First Name	Preferred Name/Pronoun	Title: ☐ Miss ☐ Ms ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Rev
Address:		Apt. #	Date of Birth (MM/DD/YYYY)
City:	Prov.	Postal Code	Occupation:
Email: We use email for appointment notification and reminders		Health Card #: Expiry (MM/YY):	
Please check off preferred contact. Home Phone: ☐ Ok to leave a message on voicemail or answering machine ☐ Yes ☐ No	Cell Phone ☐ Ok to leave a message on voicemail or answering machine ☐ Yes ☐ No	Business Phone ☐ Ok to leave a message on voicemail or answering machine ☐ Yes ☐ No	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

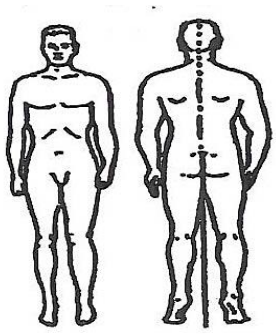
Current/Previous Therapies

Please check off any of the following care you are currently receiving or have received in the past;
☐ Chiropractic ☐ Physiotherapy ☐ Podiatry ☐ Massage Therapy ☐ Acupuncture ☐ Athletic Therapy
☐ Psychology ☐ Registered Dietitian ☐ Voice Therapy ☐ Speech Therapy ☐ Sports Medicine Physician
☐ Pelvic Health/Floor Physiotherapy ☐ Other

If yes, for what? _____

Name of Practitioner: _____

On the diagram provided, please indicate where you feel pain or tenderness with an "X" and where you feel numbness or tingling with a "Y"



Describe your pain (ie sharp, dull, shooting, throbbing):

What is your current level of pain 0 (no pain) to 10 (worst possible pain)?

What increases your pain?

What decreases your pain?

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Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke / CVA
- ☐ pacemaker or similar device
- ☐ heart disease
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ sensitivity to heat /cold
- ☐ Anemia
- ☐ Swollen ankles

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

Digestive
- ☐ Abdominal Pain
- ☐ Colitis/Crohn's disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Hernia
- ☐ Other: _____

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

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

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

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

Genito-Urinary
- ☐ Fecal Leakage
- ☐ Frequent Urination
- ☐ Kidney Conditions
- ☐ Prostrate Problems
- ☐ Prolapse
- ☐ Urinary Leakage

Other Conditions
- ☐ depression
- ☐ anxiety
- ☐ diabetes
- ☐ fatigue
- ☐ Numbness/Tingling
- ☐ Loss of Sleep
- ☐ Unusual weight loss/gain
- ☐ Blood conditions and/or disease
- ☐ loss of sensation, where?

_____

- ☐ allergies / hypersensitivity to

what?_____
Reaction type:_____
- ☐ epilepsy
- ☐ cancer, where?_____

Was radiation therapy required? ☐ Yes ☐ No
- ☐ arthritis, type_____

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

Women
- ☐ pregnant, due:

_____
gynecological conditions,
what? _____

Number of pregnancies
Delivery Type: ☐ Vaginal ☐ Cesarean
- ☐ Nursed in the past
- ☐ Currently nursing
- ☐ Diastasis
- ☐ Menopause
- ☐ Other:_____
- ☐ Complications during any

pregnancy or delivery:
_____

Skin
- ☐ Bruise Easily
- ☐ Skin Eruptions/Rash
- ☐ Warts
- ☐ Eczema
- ☐ Psoriasis
- ☐ infectious condition
- ☐ other _____

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.	

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Have you been in an auto accident? ☐ Yes ☐ No Describe: ☐ Past Year _____ ☐ Past 5 years _____ ☐ Over 5 years _____ ☐ Never	Have you had any other personal injury or accident? ☐ Yes ☐ No Describe: ☐ Past Year _____ ☐ Past 5 years _____ ☐ Over 5 years _____ ☐ Never

Chiropractic, Massage Therapy, Physiotherapy, Pelvic Health/Floor Physiotherapy, Acupuncture, Podiatry, Athletic Therapy, and Voice Therapy **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. (Sports Medicine Physicians are covered under OHIP).

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

In case of lateness, your assessment and treatment time will be reduced appropriately, and the full treatment charge will apply. We require **24 hours notification** for all 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): _____

Date of Birth: _____

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CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with any of the above services, Rehab and Wellbeing will collect some personal information about me (e.g., home telephone number, address, health history, social history).

I have reviewed the Rehab and Wellbeing Centre Privacy Policy (available at the front desk) about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction. I understand that, as explained in the Privacy Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I understand that I can request a hard copy of the Privacy Policy.

I agree to Rehab and Wellbeing Centre collecting, using and disclosing personal information about me as set out above and in the Rehab and Wellbeing Centre Privacy Policy. I understand that Rehab and Wellbeing Centre does not sell any information pertaining to any patients, including myself.

I consent to allowing Rehab and Wellbeing Centre and its practitioners, to discuss the health information collected during my evaluation and ongoing treatment, my progress, changes in my condition, and treatment plan of care with referring practitioners, other allied health professionals and fitness professionals for the purpose of coordinating care and optimizing treatment outcome.

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 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.

Signed: _____ Date: _____

Patient's Name (please print): _____

Date of Birth: _____