MAPLE RIDGE
PHYSIOTHERAPY
& PAIN CLINIC

Chronic Pain, Orthopaedics & Sports Injuries, Acupuncture,
Massage Therapy, ICBC and WorkSafeBC Claims
#102-22561 Dewdney Trunk Road Maple Ridge, BC V2X 3K1
Phone: (604) 467-8775 . Fax: (604) 467-8704
www.mapleridgephysio.com

HEALTH QUESTIONNAIRE (3 PAGES)

Date (YYYY/MMM/DD):_____

NAME (as listed on your BC Care Card):_____

Date of Birth (YYYY/MMM/DD):_____

Medical History

1. Date of last medical physical exam (YYYY/MMM/DD):_____

2. Please check any of the following for which you have been diagnosed or treated by a physician or other health professional:

- ☐ Alcoholism
- ☐ Anemia (☐ iron deficiency, ☐ sickle cell)
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Bronchitis, chronic
- ☐ Cancer: _____ (☐ active or ☐ in remission)
- ☐ Chronic fatigue syndrome
- ☐ Cirrhosis, Liver
- ☐ Concussion/ Head Injury
- ☐ Congenital Defect
- ☐ Coordination problems
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes (☐ Type 1 ☐ Type 2 ☐ Gestational)
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye problems
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hearing loss
- ☐ HIV/AIDS
- ☐ Heart Problem
- ☐ Hepatitis (check): ☐ A ☐ B ☐ C
- ☐ Hemophilia
- ☐ Hernia:_____
- ☐ High blood glucose (sugar)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular menstruation
- ☐ Kidney Problem
- ☐ Loss of memory

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☐ Loss of mensuration (pre menopause) ☐ Obesity ☐ Mononucleosis

☐ Multiple Sclerosis ☐ Organ Transplant ☐ Osteoporosis

☐ Pneumonia ☐ Pacemaker ☐ Peripheral Vascular Disease

☐ Phlebitis ☐ Spinal Cord Injury ☐ Tuberculosis

☐ Stroke (what year):_____ ☐ Ulcer ☐ Infectious Blood Disease

☐ Under/☐ Overactive Thyroid OTHER:_____

3. Are you pregnant? ☐ Yes / ☐ No If yes, how many months/weeks:_____

4. Allergies (e.g. insect, food, drug):

_____

_____

5. List any hospitalizations in the last year and all surgeries you've had:

_____

_____

6. Has your weight fluctuated more than a few pounds in the past year? ☐ YES / ☐ NO

If yes, describe:_____

7. List any medication or supplements that you have been taking over the last six months, and specify those that have been prescribed by a Medical or Naturopathic doctor:

_____

_____

_____

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8. Please select yes or no regarding your experience with each statement during the last six months:

Pain or discomfort in the chest, neck, jaw, or arms that is NOT a result of an injury. ☐ Yes ☐ No

Shortness of breath or chest pain when walking with others your age? ☐ Yes ☐ No

Dizziness/ Faintness? ☐ Yes ☐ No

Loss of consciousness? ☐ Yes ☐ No

Ankle swelling that is not the result of a recent trauma or injury? ☐ Yes ☐ No

Irregular heartbeat? ☐ Yes ☐ No

Pain in the back of the lower leg and trouble walking that is NOT a result of trauma or injury?

☐ Yes ☐ No

9. Has anyone in your immediate family (1st degree relative) experienced any of the following:

Died of a heart attack or suddenly before the age of 65? ☐ Yes ☐ No

Had heart surgery? ☐ Yes ☐ No

Been diagnosed with osteoarthritis? ☐ Yes ☐ No

Been diagnosed with rheumatoid arthritis? ☐ Yes ☐ No

_____ _____

Patient Name Date (YYYY/MMM/DD)

☐ **I agree that checking this box constitutes an electronic representation of my signature and I certify that the above medical information is correct to my knowledge.**

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