Magna Health CENTRE
Integrated | Compassionate | Effective Care

Dear New Patient,
Please complete the following questionnaire as fully and carefully as possible. Your answers will help us 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: _____

Home Telephone:_____ Business Telephone:_____ Cell:_____

Email:_____ Family Doctors Name:_____ Phone Number:_____

Occupation: _____ Emergency Contact Name:_____
Phone Number & Relation: _____

How were you referred to our clinic?_____ OHIP Number:_____

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):
_____
_____
_____

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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
__Stroke
__High Blood Pressure
__Low Blood Pressure
__Circulatory Disorders
__Varicose Veins
__Pacemaker
__Phlebitis
__Heart Disease
__Chronic Congestive Heart Failure
__Myocardial Infarction

RESPIRATORY
__Emphysema
__Asthma
__Chronic Cough
__Bronchitis
__Breathing Difficulty
__Lung Disorder

NEUROLOGICAL
__Epilepsy
__Multiple Sclerosis
__Loss of Sensation
__Neuritis
__Other _____

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

SKIN
__Bruise Easily
__Eczema / Psoriasis
__Rash
__Cold Sores / Warts
__Herpes
__Athlete's Foot
__Loss of Sensation
__ Other_____

HEAD & NECK
__Headache
__Migraine
__Visual Disturbances
__Earaches
__Hearing Problems
__Teeth / Jaw Pain
__Locked Jaw
__Sinus Pain
__Injury
__Dizziness / Vertigo

SOFT TISSUE & JOINTS
__Neck
__Shoulder
__Arm / Elbow
__Chest
__Abdomen
__Upper Back
__Mid Back
__Lower Back
__Hip
__ Leg
__ Knee
__ Ankle

GENITOURINARY
__Hemorrhoids
__Prostate Problems
__Sexual Dysfunction
__Hernias

__Menstrual Problems
__Menopausal Problems
__Endometriosis
__Previous C-Section
__PCOS

OTHER
__Allergies
__Arthritis
__Cancer
__Carpal Tunnel Syndrome
__Chronic Fatigue Syndrome
__Diabetes
__Fainting
__Fibromyalgia
__HIV / AIDS
__Hemophilia
__Hepatitis
__Insomnia
__Osteoporosis
__Scoliosis
__Tuberculosis

INJURIES
__Muscle Strain
__Ligament Sprain
__Fracture
__Whiplash
__Herniated Disc
__Other:_____

SURGICAL IMPLANTS
__Pins
__ Plates
__Artificial joints:
__Other: _____

Other Conditions Not Listed Above: _____

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

Heart disease _____ High blood pressure _____
Cancer _____ Diabetes _____
Stroke _____ 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/wk___

Do you wear orthotics Yes No
How long have you had this pair? _____

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

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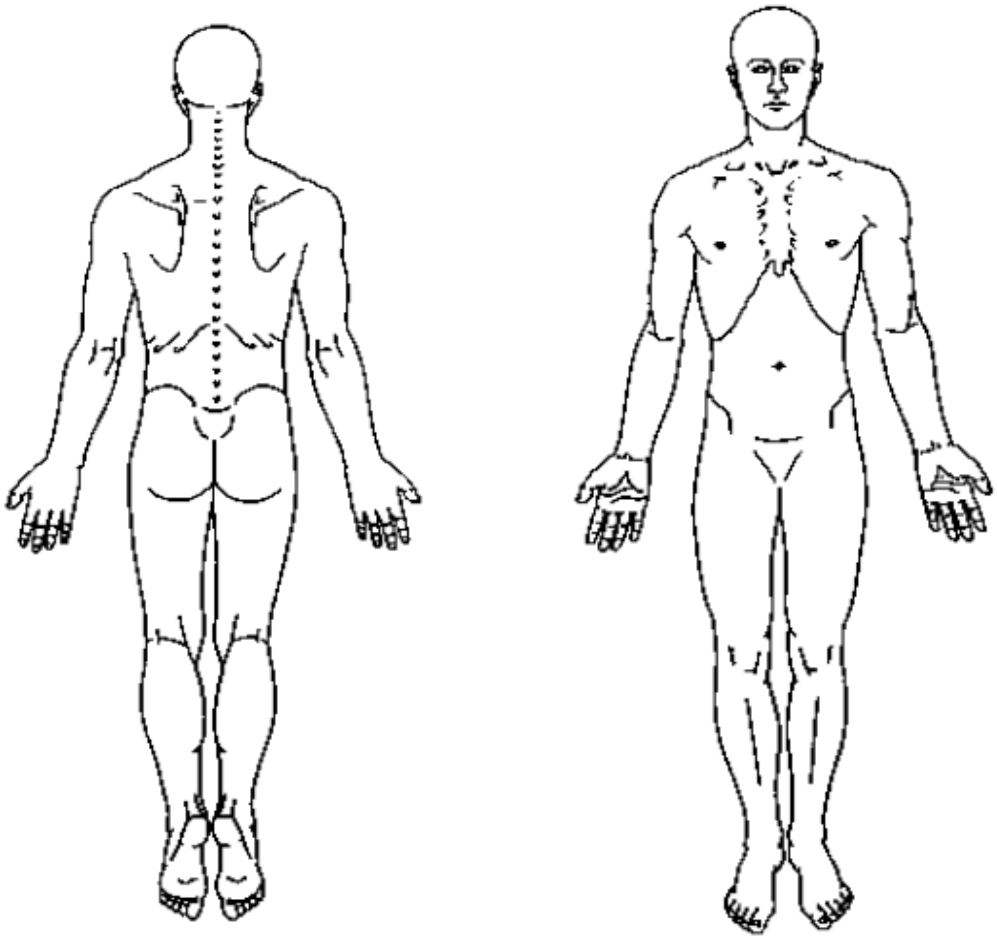
Name:_____ **Date:**_____

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 //////////
Burning xxxxxxx	Sharp & Stabbing oooooo	Stiff and Tight +++++++



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:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

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