Sun Country Health Region

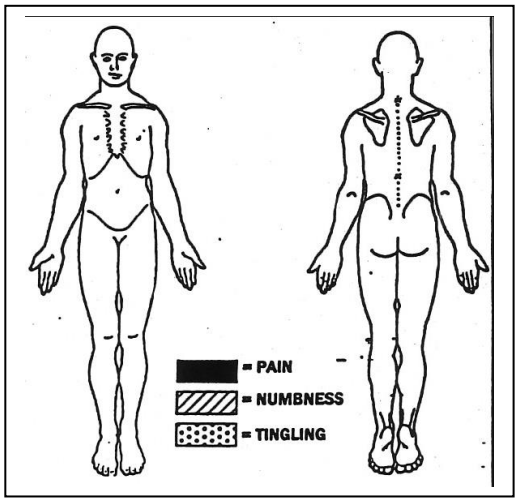
THERAPY SERVICES

FOR OFFICE USE ONLY
Date Sent:_____
Date Returned:_____
Score:_____
Appointment:_____

CLIENT QUESTIONNAIRE **Re:**

Name:	Occupation: Employer:
Health Card Number:	Date of Birth: dd _____ mm_____ yy_____
Telephone Numbers: Home: _____ Work: _____ Cell: _____ Other: _____ E-mail:_____ Short Notice? Yes ___ No ___	
1. Why are you seeking treatment?	
2. Is your problem due to an injury? ☐ Yes ☐ No Date of injury: _____	
3. Have you seen a specialist? ☐ Yes ☐ No Did you have surgery? __Yes __ No Dr. _____ Date _____	
4. Are you currently off work? ☐ Yes ☐ No	
5. Claim: If applicable ☐ WCB ☐ SGI Claim number:_____ ☐ Other _____	
6. List any other health conditions you may have? (Surgeries, heart, diabetes, asthma, cancer, seizures, pregnancy, pacemaker etc.)	
7. Are you currently taking medications/supplements? ☐ Yes ☐ No If yes, please list:	
8. How long have you had this problem? ☐ Up to 6 weeks ☐ 6 weeks to 3 months ☐ Over 3 months, Specify:	

9. Please mark the areas on your body (using the diagram) where you feel the described sensations.
Use the appropriate symbol.
Include all affected areas.
Comments:



10. List up to three activities you are having difficulty with as a result of your problem and how much they are affected on a scale of 0-10 (0 meaning not at all; 10 meaning unable to do).

_____ _____ 0 1 2 3 4 5 6 7 8 9 10

_____ 0 1 2 3 4 5 6 7 8 9 10

_____ 0 1 2 3 4 5 6 7 8 9 10

11. Overall, are you getting: ☐ Better ☐ No change ☐ Worse

12. a) Does your symptom(s) keep you from falling asleep at night? ☐Yes ☐No
b) Does your symptom(s) wake you during the night? ☐Yes ☐No

13. Is your symptom(s) ☐Occasional ☐Frequent ☐Constant

14. Over the last two weeks, how often have you been bothered by either of the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
Little interest in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

15. Have you received any previous physiotherapy treatment for this problem? ___ yes ____no

What do you hope to gain from treatment?

_____

_____

Date: dd _____ mm _____ yy _____

Client's Signature: _____