DunbarPhysio

PATIENT INFORMATION AND ASSESSMENT

(Confidential)

Name: _____ **DOB:** _____ **Sex:** M F

Care Card #_____ **Family Dr.** _____

Occupation: _____ **Hobbies**:_____

How Did you hear about us:_____

ADDRESS: _____

CITY/TOWN _____ PROV_____ P/C _____

PHONE (H) _____ (W) _____ (M) _____

EMAIL_____

WORKSAFE BC AND ICBC PATIENTS

DO YOU HAVE A DOCTOR'S REFERRAL? ☐ YES ☐ NO

CLAIM NUMBER: _____ DATE OF INJURY_____

ADJUSTER NAME: _____ PHONE # _____

Current Assessment Date:_____

Name: _____ **DOB:** _____

Email: _____ **Family Dr.** _____

Occupation: _____ **Hobbies**:_____

☐ **Injured at work**

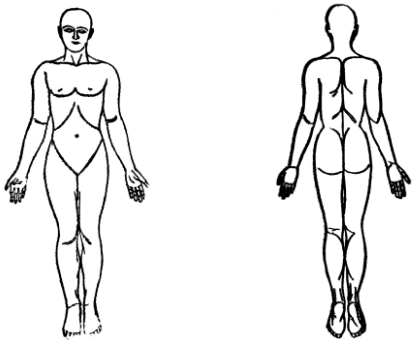
☐ **Injured in Motor Vehicle Accident**

Complaints & Symptoms:
List below and mark on chart

_____

_____

_____



Other Symptoms

☐ Headaches	☐ Nausea	☐ Double Vision/Eye Issues
☐ Vertigo/Dizziness/Light-head	☐ General Malaise	☐ Loss of consciousness
☐ Pins and Needles/Numbness	☐ Sleep Disturbance	☐ Difficulty Speaking
☐ Bowel and/or bladder changes	☐ Recent unexplained weight change	☐ Difficulty Swallowing

Medication: ☐ Steroids (past/present) ☐ Blood Thinners ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____ ☐ _____

Investigations – for this problem & date

☐ X-Ray ☐ CT Scan ☐ Other
☐ MRI ☐ US Scan

Pain: ☐ Improving ☐ Same ☐ Worsening

☐ Constant ☐ Intermittent

Activities/movements that worsen your pain: _____

Activities/movements that improve your pain: _____

Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Medical History

☐ Cancer (past or present)	☐ Osteo/Rheumatoid Arthritis	☐ Pregnant (or trying)
☐ Radiation Therapy (last 6 months)	☐ Osteoporosis	☐ Family History of Disease
☐ Chemotherapy (last 6 months)	☐ Diabetes	_____
☐ Cardiac Pacemaker	☐ Surgeries	☐ Other
☐ Heart Issues (past or present)	☐ Broken Bones	_____