Dr. Janine Reid, MD, FRCPC Physiatry, CSCN dip. (EMG)
Coastal Rehabilitation and Neurodiagnostics
502-1515 Dufferin Cres Nanaimo, BC V9S 5H6
P: 778-787-1707 F: 250-713-4422

PATIENT INTAKE QUESTIONNAIRE (Dr. Reid Patients)

Mr. Ms. Mrs. Mx. Dr. (circle one) **Full name**: _____

Handedness: Right Left Both

Assigned Sex: Female Male Intersex

Height:_____ **Weight:**_____

Gender: (Man/Woman/Nonbinary/Fill in the blank)
_____

Do you have **private health insurance**? YES NO
Provider: _____

Relationship status: (married/single/live-in partner)
_____

Is this issue from a **work related** incident? YES NO
Is this issue from a **motor vehicle** incident? YES NO
Claim number:_____
Date of injury:_____

Occupation: _____
Working Status: Full time Part Time
On disability Student Homemaker Retired

What is the **main** reason for your appointment today?

_____

What are your **main** symptoms?

_____

_____

How long have you had these symptoms? _____ Are they getting: better worse same

Please list previous **physicians** you have seen for this issue:

_____

_____

Please list **previous tests** related to this issue (e.g. bloodwork, X-ray, CT, MRI, nerve studies/EMG, etc.)

_____

_____

Please list **previous treatments** that you have had for this issue (e.g. therapy, medication, injections, surgeries)

_____

_____

_____

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Please **circle** any **health care providers** you have seen for this issue:

Physiotherapist Athletic Therapist Chiropractor Massage Therapist Kinesiologist

Acupuncturist Naturopath Podiatrist Counsellor/Psychologist/Psychiatrist

Do you currently have any **unexplained**: Weakness Numbness Fever/chills Tingling/pins/needles

Weight loss Fatigue or low energy Night sweats

Bowel or Bladder Incontinence (accidents)

Difficulty with walking or balance

Current or previous **cigarette** smoker? How many years: _____How many packs per day:_____

Do you drink **alcohol**? How many drinks per day/week?_____

Do you use any **other drugs** (marijuana, opioids, stimulants, hallucinogens)? Type? How much and how often?

_____

What do you do for **regular exercise**, if any? How often/how many minutes per week?

- ❑ Aerobic (e.g. walking, running, elliptical, cycling, swimming) _____
- ❑ Resistance (e.g. free weights, exercise bands, machines) _____
- ❑ Flexibility (e.g. stretching, yoga) _____
- ❑ Other (please describe) _____ _____

Describe your goals for coming to the clinic (e.g. find a cause or diagnosis, reduction in pain or symptoms, help with coping):

_____

_____

_____

_____

Anything else important for your doctor to know?

_____

_____

_____

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Current Medications (including over the counter, supplements, herbal remedies etc.):	Dose and timing:

Please underline blood thinners (e.g. Plavix/clopidogrel, Coumadin/warfarin, etc.)
Please star *pain medications *

Medication Allergies:	Reaction:

Past Medical History (include current conditions, past hospitalizations) (e.g. diabetes or high blood sugar tests, high blood pressure, thyroid problems, neurologic conditions, osteo/rheumatoid arthritis, autoimmune or rheumatologic conditions, mental health conditions, heart disease, lung disease, kidney disease etc.):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any history of **childhood medical illness**?

Past Surgeries (list type and year):

_____ _____

_____ _____

_____ _____

Family Medical History (list their relation to you, the diagnosis, include chronic pain conditions, neurologic conditions, osteo/rheumatoid arthritis, autoimmune disorders, etc.): _____

_____