COASTAL
REHABILITATION + NEURODIAGNOSTICS

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Dr. Philip Motyka MD, FRCPC, CSCN (EMG) Specialists in Physical Medicine and Rehabilitation

Mr Mrs Ms Miss Dr (circle one)	Full Name: Birthdate: Address:				
Age _____	Sex:	Male ☐ Female ☐	Handedness:	Right ☐ Left ☐ Ambidextrous ☐	
	Height:	Weight:			

Description of Symptoms

What is the main reason for your appointment today?	
In brief, please describe your symptoms (the main reason for today's appointment)	
How long have these symptoms been bothering you for?	
What treatments have you tried for this problem?	

Past Medical History		
Please list your medical conditions		
Do you have any history of abnormal blood sugar tests? (diabetes, prediabetes, impaired fasting blood sugar or gestational diabetes?)	Yes ☐ No ☐	If yes, which type?
Do you have any history of thyroid problems diagnosed by a physician?	Yes ☐ No ☐	If yes, which type?
Do you have any history of autoimmune disorders diagnosed by a physician? (This may include lupus, rheumatoid arthritis, sjogrens syndrome, spondyloarthritis, celiac disease, psoriasis, ulcerative colitis, chrohn's disease)	Yes ☐ No ☐	If yes, which type?

Do you have any history of significant childhood medical illness?	
Do you have any history of mental health and/or substance abuse disorders? If yes, please specify	
Past Surgical History	
Please list your previous surgeries and the year in which the surgery occurred (if possible)	
Medication History	
Please list your current medications and supplements (use separate sheet, or attach a list if necessary)	
Do you have any allergies to medications?	Yes ☐ No ☐
Please list your allergies and indicate the reactions (hives, nausea, anaphylactic, etc)	

Social History			
Highest Level of Formal Education	0-8 years ☐ 8- _____ 12 years ☐ _____ Diploma ☐ _____ Degree ☐ _____ Specialized _____ Qualifications ☐ _____ _____	Work Status:	Student ☐ Homemaker ☐ Retired ☐ On Disability ☐ Working ☐ If yes, last job worked:_____ If indicated, place and/or type of work:_____
Behaviours that may affect health status			
Do you smoke cigarettes?	Yes ☐ No ☐	IF yes, how many per day?	
Do you drink alcoholic beverages?	Yes ☐ No ☐	IF yes, how many per week?	
Do you have any recreational drug use?	Yes ☐ No ☐	IF yes, which type and how often?	
Family History (If family history is unknown, please indicate)			
Are you aware of any family history of neurological disorders?	Yes ☐ No ☐	IF yes, what is the diagnosis? What is their relation to you?	
Are you aware of any family history of autoimmune disorders?	Yes ☐ No ☐	IF yes, what is the diagnosis? What is their relation to you?	