Name: _____

Home Address: _____

_____

Telephone: H _____ W _____

Date of Birth:(dd/mm/yyyy) _____

Family Doctor _____

Employer/Job:_____

eMail _____

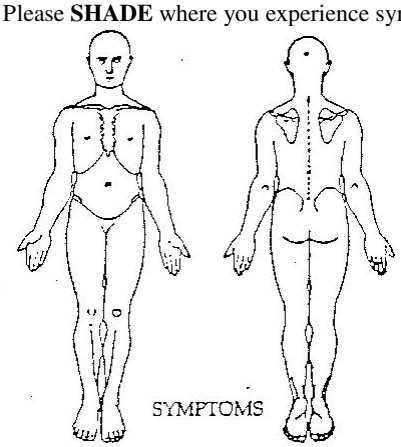
WHSCC Claim # _____

MCP (Not for billing)

_____

Present Injury

Please **SHADE** where you experience symptoms



Rate the ***Intensity*** *of your current pain* by placing a dash on the line below:

No Pain _____ Unbearable Pain

Briefly describe **WHEN** and **HOW** your injury or pain began:

_____

_____

_____

What time of day or activity makes your pain or problem worse

_____

_____

What typically makes your pain or problem better?

_____

_____

_____

Please **DATE** any special tests that were done

dd/mm/yyyy

XRAY	
ULTRASOUND	
EMG STUDY	
BONE SCAN	
CT SCAN	
ARTHROSCOPE	
MRI	

Medical History

Please check any that apply:

- ☐ Diabetes ___ Type 1 ___ Type 2
- ☐ Osteoporosis (brittle bones)
- ☐ Arthritis
- ☐ Heart Attack/Angina
- ☐ High blood pressure
- ☐ Abnormal heart rate
- ☐ Pacemaker
- ☐ Depression or Anxiety disorder
- ☐ Stroke
- ☐ Fibromyalgia
- ☐ Cancer
- ☐ Currently Pregnant
- ☐ Other: _____

Please list any past surgeries:

_____

_____

_____

Medications:

_____

_____

Check any symptoms that you experience:

- ☐ Unexplained weight loss
- ☐ Dizziness
- ☐ Fever/Chills
- ☐ Difficulty speaking or swallowing
- ☐ Night sweats
- ☐ New lumps
- ☐ Fainting
- ☐ Blurred vision

Therapist _____ Date _____