HARVARD
REHABILITATION
201-801 Mohawk Rd. West, Hamilton, ON L9C 6C2 Tel: (905)538-2300 www.harvardrehab.net

CONFIDENTIAL NEW PATIENT RECORD

Name(last, first):_____ DOB(dd/mm/yy):_____ Age:____ Sex: ☐M ☐F

Address:_____ City:_____ Postal code:_____

Home Phone:_____ Cell phone:_____ Bus. Phone:_____

Occupation:_____ Employer:_____

Family Doctor: _____

Please check: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Common-law

How did you hear about our clinic? ☐ Doctor's referral ☐ Friend/Family ☐ Internet ☐ Signage ☐ Other_____

If applicable:

Name of Spouse:_____ Spouse's Employer:_____

Emergency Contact Person:_____ Phone:_____

CURRENT HEALTH CONDITION

• Area of Complaint: _____

• If pain/injury, what was the mechanism? ☐Workplace injury ☐Auto accident ☐Slip/Fall ☐Sports injury ☐Unknown

☐Other (please describe):_____

• Specific date when this condition started:_____

• On a scale of 1-10 (10 being the worst), what range would you rate your pain (best to worst): /10

• How would you describe your pain? (please check):

☐Dull/ache ☐Sharp ☐Stabbing ☐Throbbing ☐Electrical ☐Shooting ☐Numbness/Tingling

• Does your pain travel to any other part of your body such as your arms, legs, buttocks or groin? ☐Yes ☐No

If yes, please describe location:_____

• Which of the following activities makes your condition **worse?** (please check all that apply):

☐Bending ☐Lifting ☐Twisting ☐Coughing ☐Sneezing ☐Straining ☐Sitting ☐Standing ☐Reaching

☐Walking ☐Running ☐Up/down stairs ☐Lying on stomach ☐Lying on back ☐Lying on side ☐Stress

• Which of the following makes your condition **better?** (please check all that apply):

☐Heat ☐Ice ☐Mobility ☐Rest ☐Medication ☐Lying on stomach ☐Lying on back ☐Lying on side

☐Sitting ☐Standing ☐Stretching ☐Exercise ☐Nothing makes it better

• Are you taking any medication **specifically for this condition**? ☐No ☐Yes, type/dose:_____

• Have you had any imaging for this condition? X-ray, MRI, CT, EMG ☐No ☐Yes, what/when:_____

• Have you ever suffered from this or a similar type of condition in the past? ☐No ☐Yes, when:_____

• If "yes", did you receive treatment for the condition? ☐No ☐Yes, what/who: ☐Medical Specialist ☐Chiropractor

☐Physiotherapist ☐Massage therapist ☐Surgery ☐Medication ☐Injections ☐Other:_____

PAST MEDICAL HISTORY

• What is your dominant hand? _____ Height: _____ Weight: _____

• Past surgery/hospitalizations:_____

• Major accidents/trauma(s):_____

• Do you have any metal implants such as pacemakers? ☐ No ☐ Yes, please specify:_____

• Do you have any serious allergies (including latex)? ☐ No ☐ Yes, please specify:_____

• Do you currently use any braces? ☐ No ☐ Yes, please indicate reason:_____

• Do you currently wear a custom foot orthotic? ☐ No ☐ Yes, please indicate reason:_____

• Do you currently smoke cigarettes? ☐ No ☐ Yes, please indicate amount/day:_____

• Do you currently drink alcohol? ☐ No ☐ Yes, please indicate amount/week:_____

• Do you have a family history of any physical/mental disease: ☐ No ☐ Yes, please specify: _____

_____

Below are list of conditions that may seem unrelated to your appointment. However, these questions must be answered carefully since they may be indirectly related to your complaint and may affect the course of treatment.

Please check any of the following diseases you have had:

☐ High blood pressure
☐ High cholesterol
☐ Stroke
☐ Hepatitis
☐ HIV-AIDS
☐ Thyroid
☐ Heart disease
☐ Anemia
☐ Hemophilia
☐ Diabetes
☐ Cancer
☐ Fibromyalgia
☐ Ankylosing spondylitis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Osteoporosis
☐ Depression/mental disorder
☐ Skin disorders
☐ Epilepsy/Seizures
☐ Migraine/headache

• Please list any other medical condition(s) you have which is not listed above:_____

• Please list all current medications not listed earlier:_____

_____

Please check any of the following symptoms you have had in the past 12 months:

GENERAL:
☐ Sudden height change
☐ Sudden weight change
☐ Fever/Chills
☐ Night sweats
☐ Chronic fatigue
☐ Pain at night
☐ Insomnia
☐ Excessive bruising

MUSCULO-SKELETAL:
☐ Low back pain
☐ Neck pain
☐ Muscle weakness
☐ Arm/leg pain
☐ Muscle cramps
☐ Foot/arch pain
☐ Swelling
☐ Stiffness/↓motion

NEUROLOGICAL:
☐ Confusion
☐ Dizziness
☐ Fainting
☐ ↓ sensation
☐ Numbness
☐ Tingling
☐ Cold hands/feet
☐ Tics/spasms

CARDIOVASCULAR:
☐ Chest pain
☐ Shortness of breath
☐ Blood pressure problems
☐ Heart palpitations
☐ Varicose veins
☐ Calf pain
☐ COPD
☐ Lung problems

GASTRO-INTESTINAL:
☐ Excessive bloating
☐ Pain after meals
☐ ↓/↑ appetite
☐ Constipation
☐ Excessive thirst
☐ Diarrhea
☐ Abdominal cramping
☐ Vomiting
☐ Visceral disease

URINARY:
☐ Pain on urination
☐ Difficulty urinating
☐ Frequent urination
☐ Flank pain
☐ Discoloured urine
☐ Unusual discharge
☐ Urinary tract infection

REPRODUCTIVE:
☐ Birth control pill?
☐ STD
☐ Vaginal pain/infection
☐ Breast pain/lumps
☐ Menopause
☐ Sexual dysfunction
☐ Pregnant

I (name) _____ acknowledge that the provided information is accurate and I give my consent to proceed with the examination.

Patient signature:_____ Date:_____