Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility: _____

File no.: _____

Family name, first name: _____

Date of birth: _____ ☐ F ☐ M
YYYY-MM-DD

RAMQ no.: _____ Exp. _____
YYYY-MM

Mother's name: _____

HEALTH QUESTIONNAIRE - REHABILITATION

☐ **Physiotherapy** ☐ **Occupational therapy** User's age: _____

Name of referring physician: _____ Date of next medical visit: _____
yyyy/mm/dd

Name of family physician: _____ Date of next medical visit: _____
yyyy/mm/dd

Your symptoms are: ☐ Improving ☐ Unchanged ☐ Deteriorating
You are: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous
☐ Traumatic event Date: yyyy/mm/dd ☐ Long-standing problem

Please check or specify the following items:
Occupation/Job title: _____ ☐ Working ☐ Retired ☐ On sick leave, since: _____
yyyy/mm/dd

Please check and specify the conditions that apply to you:

YES	NO		YES	NO	
☐	☐	Osteoporosis	☐	☐	Incontinence
☐	☐	Gout	☐	☐	Sexually transmitted infection/hepatitis
☐	☐	Osteoarthritis	☐	☐	Neurological problem
☐	☐	Rheumatoid arthritis	☐	☐	Recent/previous stroke
☐	☐	Fibromyalgia	☐	☐	Alzheimer's/memory loss
☐	☐	Metal implants in the body	☐	☐	Seizures/epilepsy
☐	☐	Heart problems (angina/infarction)	☐	☐	Multiple sclerosis
☐	☐	Pacemaker	☐	☐	Parkinson's
☐	☐	Phlebitis/thrombosis	☐	☐	Dizziness/vertigo/fainting
☐	☐	Vascular problems	☐	☐	Headaches/migraines
☐	☐	High blood pressure	☐	☐	Nausea/vomiting
☐	☐	Anemia	☐	☐	Balance problems/falls
☐	☐	High cholesterol	☐	☐	Cancer (recent/previous): _____ Type: _____ Date of diagnosis: _____
☐	☐	Respiratory problems	☐	☐	Loss of appetite
☐	☐	Digestive/intestinal problems	☐	☐	Fever/chills
☐	☐	Liver/gallbladder/spleen/kidney problems	☐	☐	Unexplained weight loss/gain
☐	☐	Vision problem	☐	☐	Use of immunosuppressants
☐	☐	Hearing problem	☐	☐	Use of corticosteroids
☐	☐	Thyroid disorder	☐	☐	Depression/anxiety/psychological disorder
☐	☐	Diabetes	☐	☐	Smoker: _____ cigarettes per day
☐	☐	Skin disease: _____	☐	☐	Use of alcohol/drugs Quantity/frequency: _____
☐	☐	Transplant/graft	☐	☐	Pregnant woman
☐	☐	Recent/ongoing infection: _____	☐	☐	Other: _____
☐	☐	Gynecological problem			

Family name: _____ First name: _____ File no.: _____

YES	NO	
☐	☐	Allergies: _____
☐	☐	Previous fractures and injuries (specify): _____
☐	☐	Surgeries (specify): _____
☐	☐	Medications/natural products (specify): _____
☐	☐	Medical tests (radiology/laboratory):

☐ X-ray ☐ Scan ☐ MRI ☐ Ultrasound ☐ Blood test ☐ Other, specify: _____

Results: (section reserved for professional) _____

Special interests:

☐ Leisure activities: _____

☐ Sports: _____

What are your expectations and objectives in terms of your rehabilitation?

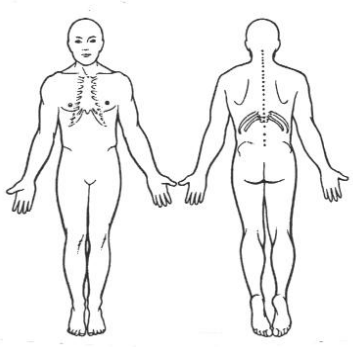
_____

Have you ever consulted a health professional for your condition (e.g., physiotherapist, osteopath, occupational therapist, massage therapist, etc.)?

☐ Yes, specify: ☐ No

Professional	Year (approximately)	Number of treatments

Diagram of body: Circle the area(s) affected by your condition.



User's signature: _____ Date: _____ yyyy/mm/dd

Professional's signature: _____ License no.: _____ Date: _____ yyyy/mm/dd

Occupation: ☐ Physiotherapist ☐ Physical rehabilitation therapist ☐ Occupational therapist

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