

Date \_\_\_\_\_

**PERSONAL INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ lbs Occupation \_\_\_\_\_

Phone \_\_\_\_\_  Home  Work  Mobile

Alt Phone \_\_\_\_\_  Home  Work  Mobile

Email \_\_\_\_\_

**ADDITIONAL CONTACT(S)**

Emergency Contact \_\_\_\_\_

Emergency Phone \_\_\_\_\_  Home  Work  Mobile

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Spouse's Phone \_\_\_\_\_  Home  Work  Mobile

**MEDICAL HISTORY**

Family Doctor Name \_\_\_\_\_

Family Doctor Phone \_\_\_\_\_  Home  Work  Mobile

What is your main  
problem/symptom?  
Please indicate  
diagnosis if known.

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When did you first notice your problem? \_\_\_\_\_

How long has your back/sciatica/stenosis/  
neck problem been at it's worst?  
Add number of (weeks, months, or years) \_\_\_\_\_

How much time (if any) have you lost because of your problem? \_\_\_\_\_

How much time has your problem interfered with your family/Family life? \_\_\_\_\_

## MEDICAL HISTORY (continued)

How much has your problem interfered with your home activities eg: Housekeeping, gardening etc

  
  

What activities are you no longer able to do or are limited in doing?

  
  

How bad does your problem feel?     Mild     Moderate     Severe

Rate your average pain/discomfort **WITHOUT** medication on a scale of 1-10, 10 being the worst

Mild           Severe

Rate your average pain/discomfort **WITH** medication on a scale of 1-10, 10 being the worst

Mild           Severe

Please indicate all previous forms of treatment/care prior to coming to Back Clinics of Canada

  
  

Please indicate any medications/drugs you are taking as a result of this problem

  
  

What do you do on your own (If any) - to help reduce the pain?

  
  

Please describe your pain, eg: sharp, dull, achy, pulling, shooting, numbing etc?

What time of day is your pain at it's worst?

Please list ANY surgeries you have had, and indicate the dates preformed

  
  

How has your quality of life changed since having this problem?

## MEDICAL HISTORY (continued)

Have you had an MRI of your problem area within the last five years?  Yes  No If yes, do you have a copy or link to the reports via Pockethealth, MyChart, disc or something else? \_\_\_\_\_

Do you have an upcoming MRI scheduled in the near future?  Yes  No If yes, when is it scheduled for (indicate date please) \_\_\_\_\_

Have you had a CT scan of your problem area in the last five years?  Yes  No If yes, do you have a copy or link to the reports via Pockethealth, MyChart, disc or something else? \_\_\_\_\_

Have you had an X-Ray of your problem area in the last five years?  Yes  No If yes, do you have a copy or link to the reports via Pockethealth, MyChart, disc or something else? \_\_\_\_\_

Do you have an upcoming scheduled appointment with a specialist (surgeon, neurologist, etc) appointment in the near future for this problem?  Yes  No

Please list in order of importance, ANY other health problems or concerns


What do you hope Back Clinics of Canada can do for you as a result of your consultation/examination?


**Thank you for completing our intake form.**

**Please take a moment to review your answers and insure the form is as complete as possible.**

**If you are unable to complete the form, contact us at (416) 633-3666 for assistance.**