The Ability Clinic
Bone • Muscle • Nerve

Pre-Appointment Questionnaire

Thank you for choosing The Ability Clinic. Please fill out this form to ensure that you receive the appropriate care. All information is *Private and Confidential*.

Date

Main Issue:

Age: Handedness: ☐Right ☐Left

This occurred after a recent injury and/or increased activity: ☐Yes ☐No
This area has been injured or bothered me previously: ☐Yes ☐No
The involved area changes throughout the day: ☐Yes ☐No
The discomfort is:
☐Sharp ☐Throbbing ☐Achy ☐Stiff ☐ Tingling ☐Electric ☐Numb

Overall, it has: ☐Improved ☐Worsened ☐Stayed the same
Discomfort: ☐Improved ☐Worsened ☐Stayed the same
Mobility: ☐Improved ☐Worsened ☐Stayed the same
Quality of life: ☐Improved ☐Worsened ☐Stayed the same

0 = No Pain; 10 = Worst Pain
Discomfort right now:
Most discomfort in last 7 days:
Average discomfort in last 7 days:
This has awoken me from my sleep: ☐Yes ☐No

The following helps:
☐Rest ☐Heat ☐Cold ☐Massage
☐Acetaminophen (Tylenol) ☐Ibuprofen (Advil) ☐Other
☐Creams ☐Prescribed medication ☐Injections
☐Brace/Splint ☐Cane ☐Crutches ☐Walker ☐Wheelchair

I have been doing the following regularly:
☐Stretching ☐Strengthening ☐Walking ☐Aerobic activity

I have seen the following professionals:
☐Physiotherapist ☐Acupuncturist ☐Massage therapist ☐Osteopath ☐Chiropractor

In the last 2 weeks, I have experienced:
☐Fevers ☐Night Sweats ☐Unintended weight loss
☐Bowel accidents ☐Urinary retention ☐Falls/Trauma

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Investigations Performed ☐Ultrasound ☐X-Ray ☐CT ☐MRI ☐Bone Scan ☐EMG/NCS

Comments:

Medical Conditions:

☐High blood pressure ☐Diabetes ☐Thyroid issues
☐Arthritis ☐Rheumatological condition ☐Neurological Condition
☐Stroke ☐Heart Attack ☐Brain Injury ☐Spinal Cord Injury
☐Other

Past Surgeries:

Medications/Supplements (*or bring list*):

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

Medication Allergies/Intolerances:

Social Information:

I live in the Greater Toronto Area: ☐Yes ☐No
There are stairs where I live: ☐Yes ☐No
I am employed: ☐Yes ☐No
My job requires many hours of: ☐Sitting ☐Standing ☐Repetitive Work ☐Physical Work I smoke tobacco and/or related products: ☐Yes ☐No
I quit smoking (year):
I drink alcohol more than 10 drinks/week (*females*) or 14 drinks/week (*males*): ☐Yes ☐No
I have previously misused substances: ☐Yes ☐No