duffins creek
Health Centre

DURHAM
SPORTS
CENTRES

FILE #:______________________________ **DATE**:______________________________

Personal Information

Name:________________________________ Home Phone:(___)____________________

Address:______________________________ Cell: (___)____________________________

City:_________________________________ Work: (___)___________________________

Postal code:___________________________ Occupation:___________________________

E-mail address:_________________________ ☐ Yes, e-mail me the clinic newsletter/event schedule

Date of Birth D/M/Y:_____________________ Age:_______ Male ☐ Female ☐

Emergency Contact:______________________ Phone Number: _____________________

Physician Information

Family Physician:_______________________ Phone Number: (___)_________________

Address:______________________________ Last Physical:__________________________

City:_________________________________

Postal code:___________________________

Other Information

How did you hear about our clinic?

☐ Yellow pages ☐ Our website

☐ Newspaper ☐ Friend/Relative

☐ Sporting Event ☐ Other: ________________

Is this the result of a motor vehicle accident? Yes ☐ No ☐

Is this a work related injury (WSIB)? Yes ☐ No ☐

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DURHAM SPORTS CENTRES

Health Status Survey

Patient Name: ______________________ File #: ________________ Date: ________________

Please X the box for any conditions or symptoms presently causing you problems.
Please check mark (√) the box for those conditions or symptoms that you have had in the past.

General Symptoms
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess sweating
- ☐ Night sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Nervousness
- ☐ Convulsions
- ☐ Loss of sleep

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Problem speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Nausea
- ☐ Clumsiness
- ☐ Numbness or tingling

Muscles and Joints
- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat
- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficulty breathing

Cardiovascular
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

GU for Women
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breasts
- ☐ Lump in breasts

Currently on birth control pills/patch?
☐ yes ☐ no

Previously on birth control pills/patch?
☐ yes ☐ no

# of pregnancies ____

# of children ____

Skin
- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Gastrointestinal
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures?
☐ yes ☐ no
If yes - where?

Have you ever been in a car accident?
☐ yes ☐ no
If yes - when?

Have you ever been hospitalized?
☐ yes ☐ no
Why/When?

Are you currently a smoker?
☐ yes ☐ no How much? __________

Did you smoke previously?
☐ yes ☐ no How much? __________

Have you ever been diagnosed:
With cancer? ☐ yes ☐ no
With HIV/AIDS? ☐ yes ☐ no
With Hep A/B/C? ☐ yes ☐ no

Medications (list):

Vitamins/Supplements (list):

Wellness/Lifestyle History

Rate your level:							
Exercise	Poor	1	2	3	4	5	Excellent
Diet	Poor	1	2	3	4	5	Excellent
Sleep	Poor	1	2	3	4	5	Excellent
General Health	Poor	1	2	3	4	5	Excellent
Stress Level	Low	1	2	3	4	5	High

Alcohol: ______ drinks/day Caffeine: _____ coffee/tea per day

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Health Status Survey

Patient Name: ______________________________ File #: ____________________ Date: ____________________

Please list your concerns in order of priority.	Cause?	How long?	Had before - when?
1. ______________________________	____________	____________	____________
2. ______________________________	____________	____________	____________
3. ______________________________	____________	____________	____________

Please indicate on the symptom diagram any of the following:

Numbness: ≡≡≡≡≡≡≡

Pins and needles: o o o o o o

Burning: x x x x x x

Sharp / stabbing: ഗ ഗ ഗ ഗ ഗ

Dull and aching: Δ Δ Δ Δ Δ Δ

Stiff and tight: 2 2 2 2 2 2