Pierre-Luc Couturier
Physiotherapist
91 Laval Street, Gatineau, QC, J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683

Health Questionnaire

Consultation date: _____ Gender: Female ❑ Male ❑

Name: _____

Date of Birth: ( ) Day • ( ) Month • ( ) Year • Age: _____

Address: _____

Town: _____ • Province: _____ • Postal Code: _____

Telephone • Home: _____ • Work: _____ ext. _____

Cellphone: _____ • E-mail: _____

❑ Yes, you may contact me via e-mail for appointment reminders, statements and all-important information regarding the clinic.
❑ No, do not contact me via e-mail.

Occupation: _____

Emergency contact: _____ • Relationship: _____

Emergency contact's phone number: _____

How did you hear about us?

❑ Internet ❑ Portage ❑ Doctor: _____
❑ Other Health Professional: _____
❑ Recommendation from another client: _____
❑ Other: _____

For CSST cases only

Event date: ( ) Day • ( ) Month • ( ) Year

Family Doctor: _____

Referring Doctor: _____

Reference date: ( ) Day • ( ) Month • ( ) Year

CSST case number: _____

Agent's name: _____

↳Agent's telephone number: _____

What is your reason for consulting? _____

Have you consulted a doctor about this problem? ❑ Yes ❑ No

Were there x-rays taken? ❑ Yes ❑ No • Date: _____

Do you take medication? ❑ Yes ❑ No

If yes please list them: _____

_____

_____

No. de dossier : _____

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Are you currently receiving other treatments for this condition? (Ex.: chiropractic, acupuncture)? ❑ Yes ❑ No • If yes, specify and indicate the treatment, and the name of the professional: _____

_____

Related Symptoms

Please check any symptoms that accompany your condition:

❑ Blurry Vision	❑ Breathlessness	❑ Difficulty Swallowing	❑ Dizziness
❑ Fatigue	❑ Fever	❑ Head aches	❑ Incontinence
❑ Loss of consciousness	❑ Nausea	❑ Numbness around the buttocks	
❑ Sweating	❑ Weight Loss/Gain	❑ Vomiting	❑ Weakness

Medical History

Please check the conditions you have now or have had in the past:

❑ Anemia	❑ Angina/Chest Pain	❑ Anxiety/Panic Attack
❑ Arthritis	❑ Bronchitis	❑ Cancer
❑ Congestive Heart Failure	❑ Craniocerebral Trauma	❑ Dependence
❑ Depression	❑ Diabetes	❑ Eating Disorder
❑ Epilepsy / Convulsion	❑ Fecal Incontinence	❑ Fibromyalgia
❑ Gout	❑ Guillain-Barré Syndrome	❑ Hemophilia
❑ Hepatise	❑ Hernia	❑ High Cholesterol
❑ High/Low Blood Pressure	❑ HIV/AIDS	❑ Hypoglycemia
❑ Liver Cirrhosis	❑ Osteoporosis	❑ Pacemaker
❑ Parkinson	❑ Peripheral Vascular Disease	❑ Pneumonia
❑ Prolapse	❑ Prostate Problems	❑ Pulmonary Emphysema
❑ Sensitivity to Heat/Cold	❑ Skin Problems	❑ Stroke
❑ Thyroid Problems	❑ Tuberculosis	❑ Urinary Incontinence