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where healthy people go

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SHOCKWAVE & ADJUNCT THERAPIES NEW PATIENT HEALTH QUESTIONNAIRE

Personal Information

Name _____

Date of Birth _____ **Age** _____

Marital Status _____ **Number of Children** _____

Names, Ages and Genders of Children

Family Doctor _____

Occupation _____

Contact Information

Address _____

City _____ **Province** _____

Postal Code _____ **Cell or Home Phone #** _____

Work Phone # _____

Email _____

How did you hear about our clinic? *(Select one)*

☐ Family member or friend
☐ Another health care provider
☐ Online search or website
☐ Social media
☐ Other _____

Who can we thank for referring you? _____

Reason for Consulting

What is your primary reason for consulting today? *(Check all that apply)*

☐ Shoulder pain
☐ Elbow pain
☐ Wrist / hand pain
☐ Hip pain
☐ Knee pain
☐ Ankle / heel / foot pain
☐ Other _____

Side Affected: ☐ Right ☐ Left ☐ Both

Nature of the Problem

Which best describes your concern? *(Check all that apply)*

☐ Joint pain
☐ Tendon pain (tendinitis / tendinopathy)
☐ Bursitis
☐ Stiffness or reduced mobility
☐ Arthritis / wear-and-tear
☐ Heel pain / plantar fasciitis
☐ Other _____

Symptom History

How long have you had this issue? ☐ < 6 weeks ☐ 6 weeks–3 months ☐ 3–6 months ☐ 6 months

Onset was: ☐ Gradual ☐ After injury or overuse ☐ Unsure

Pain & Functional Impact

Current pain level (0-10): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities make your symptoms worse? *(Check all that apply)*

☐ Walking
☐ Stairs
☐ Lifting
☐ Reaching overhead
☐ Gripping
☐ Standing
☐ Exercise / sport
☐ Daily activities
☐ Sleep

Previous Care for This Issue

Have you tried any of the following? *(Check all that apply)*

☐ Chiropractic
☐ Physiotherapy
☐ Massage therapy
☐ Injections
☐ Medications
☐ Orthotics/Braces
☐ None

Did this provice lasting relief? ☐ Yes ☐No ☐ Temporary

Relevant Medical History

Please check all that apply

☐ Osteoarthritis
☐ Rheumatoid or inflammatory arthritis
☐ Diabetes
☐ Osteoporosis / low bone density
☐ Bleeding or clotting disorder
☐ Neuropathy or nerve condition
☐ Circulatory or vascular disease
☐ Previous fracture in this area
☐ Previous surgery on this joint (date):

_____
☐ None of the above

Medications

Are you currently taking

☐ Blood thinners
☐ Corticosteroids (oral or injected)
☐ Anti-inflammatory medication
☐ None

Other medications or supplements we should know about

Treatment Goal

What is your main goal with Shockwave Therapy?

☐ Reduce pain
☐ Improve joint movement
☐ Return to activity or sport
☐ Avoid injections or surgery
☐ Improve daily function

Do you have any other health concerns we should know about?

Patient Communication Preferences

Please select your preferred method of communication for appointment reminders, confirmations, missed visits, and rescheduling.

Please choose one preference ☐ Email ☐ Text Message *

**By choosing "Text message", you give consent to receive appointment-related texts from our clinic, in accordance with Canadian Anti-Spam Legislation (CASL).*

THANK YOU FOR FILLING OUT OUR SHOCKWAVE & ADJUNCT THERAPIES NEW PATIENT HEALTH QUESTIONNAIRE! We look forward to helping you with your current health concerns and overall well-being.