



QUESTIONNAIRE

Date questionnaire completed: ____/____/____
mm/dd/yyyy

Name: _____
Last First

Address: _____ Postal Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Date of Birth: ____/____/____
mm/dd/yyyy.

Prefer to be contacted by: _____

How did you hear about Osteo-Circuit? _____

What are your reasons for joining the Osteo-Circuit?

- a. _____
- b. _____
- c. _____

Emergency Contact: _____ Phone Number: _____

Assessment Fee: _____

Consent for Assessment: _____

Family Doctor: _____ Specialist: _____

Have you been a patient of Pro Motion Physiotherapy before? Y/N

May we send your reports to doctor(s)? Y/N

We provide newsletters to our patients. Would you like to receive them? Y/N

Name: _____

PART A: Medical History

1. Please check all that apply.

	Yes
Osteoporosis	
Low Bone Density (Low Bone Density)	
Rheumatoid arthritis	
Osteoarthritis	
Heart disease	
Hypertension	
Hypotension	
Stroke	
TIA (transient ischemic attack)	
Pacemaker	
Diabetes: (if yes please circle the type) 1 = Insulin Dependent 2 = Non-Insulin Dependent Age of onset	
Asthma or other breathing problem	
Epilepsy	
Joint replacement	
Cancer (if yes, please fill in the following): Type _____ Location _____ Treatment _____	
Orthostatic intolerance – decrease in blood pressure with change of position	
Do you experience spells of dizziness/vertigo?	
Do you experience a sense of being off-balance?	
Do you leak urine (even small drops) when you cough, sneeze, bend down, lift, walk quickly, jog or exercise?	
Do you get a sudden strong and uncomfortable need to urinate that makes you rush to the bathroom?	
Women: Are you pre- or post-menopausal	

1. Date of most recent Bone Mineral Density test: ____/____/____
mm/dd/yyyy

2. (Please circle) Compared to your last test, the bone density.

For BACK:	Has Increased	Stayed the Same	Has Decreased	I'm Not Sure
For HIP:	Has Increased	Stayed the Same	Has Decreased	I'm Not Sure

Name: _____

3. What was your **greatest** height as a young adult? _____ ft. _____ in.

4. Do you personally have a history of any **other** significant illness? Yes ☐ No ☐
If yes, please describe on the two lines below:

Have you had any surgery? Yes ☐ No ☐ If yes, please provide details.

Does the surgery limit your mobility to ability to be physically active? Yes ☐ No ☐

5. In general, would you say your health is:

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

6. **Compared to one year ago**, how would you rate your health in general now?

☐Much better ☐Somewhat better ☐About the same ☐Somewhat worse ☐Much worse

PART B: Medication and Supplements

Have you been on Osteoporosis medication in the past? ☐Yes ☐No

If yes: Name of medication: _____

When started: _____

If stopped taking: When _____

Reason for stopping _____

Have you taken prednisone in the past (including inhalers for asthma)? ☐Yes ☐No

1. List of all current medications taken.

MEDICATIONS	
Name	Purpose

2. List all current vitamins or supplements (including minerals, herbal remedies, etc.)

Vitamins and Supplements	
Name	Purpose

PART C: Lifestyle

1. ALCOHOL: Do you drink alcohol? Yes ☐ No ☐

If yes (check one): ☐ 0-2/day ☐ >2/day

2. CAFFEINE: Do you drink caffeinated beverages (e.g., coffee)? Yes ☐ No ☐

If yes (check one): ☐ 0-2/day ☐ >2/day

3. Have you ever used cigarettes, pipes or cigars (presently or in the past) on a daily basis for a period of at least 6 months? Yes ☐ No ☐

Name: _____

PART D: Work, Physical Activity and Exercise

1. Presently working? Yes ☐ No ☐ _____
2. Do you presently do 150 minutes of aerobic activity per week? Yes / No
(aerobic activity includes walking jogging and biking.)
3. Do you do muscle strengthening 2 times per week? Yes / No
4. Present physical activity, exercises and hobbies:

5. Is there anything you are having difficulty doing or have stopped doing?

6. Do you currently have any pain that limits physical activity?

Locations	Pain (Mark if present)
Neck	☐ Yes
Shoulders	☐ Yes
Back	☐ Yes
Hips	☐ Yes
Thighs	☐ Yes
Knees	☐ Yes
Ankles/feet	☐ Yes

7. Do you use medication for pain at least once a week? Yes ☐ No ☐

PART E: Fall(s) History

1. Have you fallen in the past year? Yes ☐ No ☐
If yes, how many times? _____ Why? _____

Name: _____

PART E: Fall(s) History Continued...

2. How often do you feel dizzy or unbalanced while standing or walking?
- ☐ Never
☐ Rarely
☐ Sometimes
☐ Always
3. Do you have trouble:
- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Reaching overhead? | Yes ☐ | No ☐ |
| Picking up objects from the floor? | Yes ☐ | No ☐ |
| Getting in and out of the bathtub? | Yes ☐ | No ☐ |
| Walking? | Yes ☐ | No ☐ |
| Climbing stairs? | Yes ☐ | No ☐ |
| Shopping? | Yes ☐ | No ☐ |
| Preparing Meals? | Yes ☐ | No ☐ |
4. How true or false is this statement?
- I am afraid of falling.
- ☐ Definitely True ☐ Mostly True ☐ Don't Know ☐ Mostly False ☐ Definitely False

PART F: Fracture History

1. In the past year, have you fractured or broken any bones? Yes ☐ No ☐
How many times have you fractured a bone in the past year? _____
2. If you have broken a bone, please list which bones, what year, whether an X-ray was taken, and how it happened (please use the chart below).

Which bone(s)?	Year	X-ray taken? (yes/no)	How did it happen?

Is there anything else regarding your medical status/goals we should be aware of?

[illegible]