Welcome to KOPI Stem Cell. Enclosed is required information that needs to be completed to make your appointment time more efficient.

Stem Cell Clinic Phone: 613-985-STEM (7836)

Appointments: It is important to arrive on time for your appointment. If you are late for your appointment you may not been seen and there will be a charge if 24 hours' notice is not given.

NAME: _____

SIGNATURE: _____

DATE (mm/dd/yyyy) _____

KOPI Initial Consultation Questionnaire

Thank you for choosing KOPI. The most important factor in a correct diagnosis is an accurate recording of "your story" which doctors refer to as your "medical history". Please take time and care in aiding us with this **critical** step. Please carefully complete this questionnaire and return the completed questionnaire as soon as possible.

Before requesting an appointment, please mail or fax (613-344-1203) to KOPI:

1. **The completed questionnaire**
2. **A printout from your pharmacy of your medication history for the last 2 years**

Our mailing address is:
KOPI
797 Princess Street, Suite 500
Kingston
K7L 1G1

Please bring the following items to your first visit:

1. **CD's (if you have them) of X-rays, MRIs, CT scans, etc. that pertain to your chronic pain condition**
2. **A valid health card**

On the day of your appointment you will be assessed by a nurse or physiotherapist and a Pain Physician. During your visit, we will discuss injections that will aid in diagnosis and treatment of your pain, and possibly make medication recommendations to your family doctor. For further information, please visit our web site at www.kopi.ca.

A. PATIENT INFORMATION

Age _____Weight _____ Height (feet) ____ (inches)____

Name _____
Date of Birth Month_____ Day _____ Year _____
Health Card Number _____
Street Address _____
City _____ Province _____ Postal Code_____

Home Phone (_____) _____
Cell Phone (_____) _____
Work Phone (_____) _____
Email _____

Pharmacy _____ Pharmacy Phone _____
WSIB Claim # _____

Drug Benefit Program _____
3rd Party Insurance Company _____
Lawyer _____ Phone Number _____

B. PAST MEDICAL HISTORY

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

_____

_____

_____

C. PREVIOUS EVALUATION AND TREATMENT

Have you been to a Pain Management Program before? **YES** **NO** If yes, where?

_____

Which treatments made your pain better, worse, or neither? **"B"** for **Better**, **"W"** for **Worse**, and **"N"** for **Neither**. **If you haven't tried the treatment, leave it blank.**

Medications	____	Steroid Injection	____
Physical therapy	____	SynVisc	____
Brace support	____	Prolotherapy	____
Casting	____		
Nerve blocks	____		

Other _____

D. PAST SURGERY (list surgery for your pain first, please list all surgeries)

Year	Surgical Procedure	Hospital	Effect on my pain

E. PREVIOUS TESTS

What tests have been done to investigate your current problems?

Test	Year	Where (what clinic or hospital)
Plain X-rays		
CT scan (CAT scan)		
MRI scan		
Ultrasound Exam		
Bone scan		
EMG/nerve conduction		
EEG (brain scan)		
Blood tests		
Other		

F. ABOUT YOUR LIFE

Present/previous occupation? _____ Employer? _____

full time ☐ part-time ☐ light or limited duty ☐

How long have/had you been at this job? _____ How much do/did you like it? _____
Have you been off work because of pain? _____ If so, how many times and for how long?_____

G. ABOUT YOUR ALLERGIES

Please list any medications you cannot take because of allergies or other problems. Please tell us what reaction occurred with each drug.

_____
_____
_____

Are you allergic to IODINE or CONTRAST DYE? **YES** ☐ **NO** ☐

Are you on blood thinners? **YES** ☐ **NO** ☐

Are you currently taking any anti-inflammatories? **YES** ☐ **NO** ☐
(ex. Motrin, Advil, Ibuprofen, Naproxen, Arthrotec, Celebrex)

Are you currently taking any corticosteroids? **YES** ☐ **NO** ☐
(ex. Prednisone, Solumedrol, Steroid Inhaler for Asthma)

H. ABOUT YOUR MEDICATIONS

List all prescribed and over-the-counter medications (Tylenol, aspirin, etc.), nutritional supplements, herbal remedies, and homeopathic remedies you are currently taking. **Use a separate sheet if necessary.**

IMPORTANT: Be sure to mention blood thinners such as Coumadin, Warfarin, Plavix, Ticlid, Aspirin, Lovenox, etc.

Medication	Strength	How many/how often	Better/Worse/Neither	Any Side Effects
Example:				
Ibuprofen	*800 mg*	*2 tablets, 3 times a day*	*Much better*	*Upset stomach*

797 Princess Street, Suite 500
Kingston, Ontario K7K 1G1
613-344-PAIN Fax 613-344-1203
www.kopi.ca

Consent to Disclose Personal Health Information

I, _____, Date of Birth, _____,
(Please Print Name)

authorize Dr. Greg Murphy and staff at KOPI to obtain and/or send my medical records and/or imaging reports regarding my current/ongoing condition.

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Patient signature: _____ Date: _____

Clinic witness: _____ Date: _____