



UNIVERSAL HEALTH & REHABILITATION, PC

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“YOUR MULTIDISCIPLINARY HEALTHCARE SOLUTION”

Work Information:

Date:

Employer Name _____

Primary Tasks _____

Are you currently working? _____

Do you have Extended Health

Yes No

If you have Extended Health and Would like us to Bill Directly, we can do so for the following Companies:

Company Name: _____ Provider Number: _____

Group Number: _____

Please initial if you provide consent for Direct Billing

PLEASE CIRCLE ALL THAT APPLY

What Makes you feel Better?
What Makes you feel Worse?

Ice
Sitting
Turning

Heat
Standing
Working

Exercise
Lifting
Activity

Medication
Carrying
Other

Rest
Pushing

Other
Pulling

PLEASE PLACE AN X WHERE YOU HAVE PAIN TODAY

