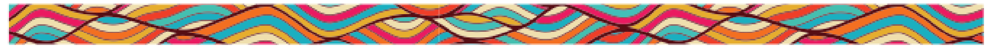
New Patient Questionnaire



PERSONAL INFORMATION

Name

Gender

Date of Birth

Age

Marital Status

Number of Children

Names, Ages, and Genders of Children

Occupation

Employer's Name

CONTACT INFORMATION

Address

City, Province, Postal Code

Home Phone #

Work Phone #

Cell Phone #

E-mail

Best Time and Phone # to Contact

HOW DID YOU HEAR ABOUT OUR OFFICE?

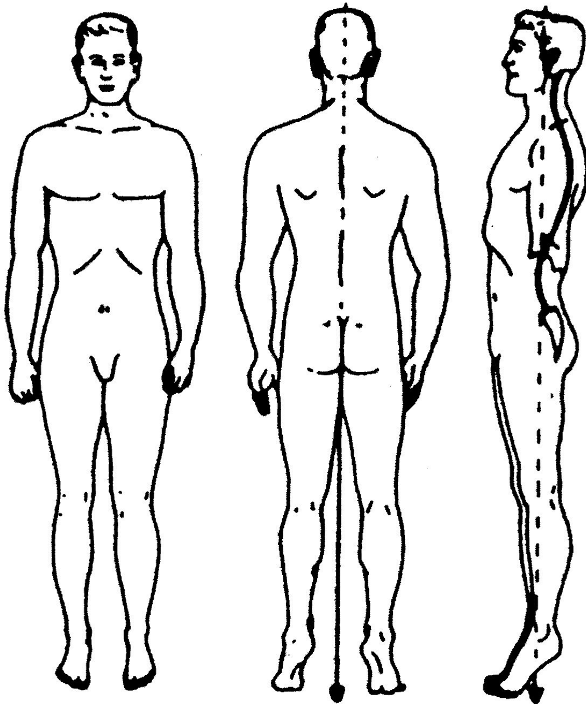
Please Check One:

- Internet Search
- Family Member
- Friend
- Co-Worker
- Health Care Professional (eg. Physician, Physiotherapist, Massage Therapist etc.)
- Other (Please Specify):

Please let us know who we can thank for referring you to our office:

WHAT BRINGS YOU HERE TODAY?

Where is the problem? Please use the diagram and lines below to explain.



How long has this been going on?

When did this incident occur?

Is this related to:

- Workplace Injury
- Sports
- Personal Injury
- Auto Accident
- Other :

Do you have:

- Pain
- Numbness
- Tingling
- Aches

Is your pain:

- Sharp
- Dull
- Throbbing
- Constant
- Intermittent

Are your symptoms affected by:

- Sitting
- Standing
- Walking
- Bending
- Lying Down
- Weather
- Other

Do your symptoms interfere with:

- Work
- Sleep
- Daily Activities
- Hobbies and Leisure Activities

On a scale of 1-10 (1 = least, 10 = most), please rate the severity of your symptoms

	1	2	3	4	5	6	7	8	9	10

Do you get headaches?

- Yes
- No

How often?

Are you receiving care from any other health professionals?

- Yes
- No

If Yes, please name them and their speciality:

GENERAL HEALTH HISTORY

Past injuries can affect present health.

Please check all that apply:

- Falls/Accidents
- Head Injuries/Concussions
- Knocked Unconscious
- Surgery
- Stroke
- Sports Injuries
- Broken Bones
- Car Accidents
- Joint Replacement
- Pacemaker

If you answered Yes to any of the above, please describe:

Please list any medications you are taking and the reason for the medication

Please list any vitamins or supplements that you are taking

Do you wear orthotics or heal lifts?

- Yes
- No

Have you ever had X-rays taken of your:

- Neck
- Back
- Neither

If Yes, please tell us where and when these X-rays were taken:

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

- Yes
- No

If Yes, please describe:

NERVOUS SYSTEM REVIEW

Your central nervous system (brain and spinal cord) is the master controller of your body. It controls the function of every cell, tissue, and organ. The connection between your brain and your body is through the spinal nerves: sensory, motor, and autonomic nerves. Please review the following system to determine if there may be a connection between your health profile and your nerve interference.

Cervical Nerves

- Eye Strain
- Red Eyes
- Vision Problems
- Weight Gain
- Ear Infection
- Ringing in the Ears
- Ear Discharge
- Crave Sweets
- Hearing Loss
- Sinusitis
- Runny Nose
- Memory Loss
- Canker Sores
- Sore Throat
- Sore Gums
- Nightmares
- Inner Ear Problems
- Speech Difficulty
- Cavities
- Tonsillitis
- Hoarse/Laryngitis
- Headaches
- Migraines
- Emotional Instability
- Chronic Fatigue
- Dizziness
- Anxiety
- Insomnia

Upper Thoracic Nerves

- Asthma
- Chest Pain
- Pain over Heart
- Difficulty Breathing
- Persistent Cough
- Bronchitis
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- High Blood Pressure
- Heart Problems
- Numbness in Hands
- Lung Problems
- Fluid Retention
- Pleurisy
- Difficulty Swallowing
- Nausea
- Gall Bladder Attacks
- Bloating
- Intolerance to Fatty Foods

Mid Thoracic Nerves

- Poor Appetite
- Excessive Hunger
- Gastric Ulcer
- Crave Sweets
- Difficulty Swallowing
- Excessive Thirst
- Liver Trouble
- Vomiting Food
- Abdominal Pain
- Diarrhea
- Immune Deficiencies
- Constipation
- Pancreatitis
- Black Stool
- Hypoglycemia

Lower Thoracic Nerves

- Allergies
- Sneezing
- Overwhelmed
- Digestive Complaints after Eating
- Appendix Problems
- Bladder Problems
- Kidney Problems
- Testicular or Ovarian Problems
- Bladder Infections
- Swollen Ankles
- Dizziness upon Standing

Lumbar Nerves

- Bladder Trouble
- IBS
- Bad Breath
- Flatulence
- Bowel Problems
- Painful Urination
- Infertility
- Dark Circles under Eyes
- Impotence
- Dysmenorrhea
- Prostate Problems
- Reproductive Disorders
- Female Problems
- Hemorrhoids
- Varicose Veins
- Hormonal Imbalances

HEALTHY LIVING AND WELLNESS SELF-ASSESSMENT

Our centre is a wellness-oriented chiropractic practice for health-conscious, wellness-minded individuals and their families. We strive to improve the overall health and wellbeing of our patients, and take a proactive approach to health care so that our patients may live healthier, happier lives. To better understand your health and wellbeing, it is important that we review your lifestyle habits.

Please score yourself according to how well you match the following statements:

1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Always

Your Fitness

	1	2	3	4	5
I am happy with my current weight					
I regularly track my personal health measures such as weight and blood pressure					
I am happy with my body composition (muscle mass vs fat mass)					
I get at least 30 minutes of moderate aerobic activity 3 to 4 days per week					
I participate in strength training exercises at least twice per week					
I am satisfied with my level of energy					
I am able to complete my activities of daily living with little or no difficulty					
I stretch 2 to 3 times per week or after work-outs					
I feel I have a strong core with no or very little back pain					
I am happy with my current level of fitness					

Your Nutrition

	1	2	3	4	5
I think my diet is well balanced					
I eat at least 8 servings of fruits and/or vegetables a day					
I eat breakfast every day					
I am aware that certain foods affect the way I feel					
I read the food labels on containers/boxes					
I pay attention to the amount of food I eat					
I drink 8-12 cups of water a day					
I avoid fast food and fried foods					
I don't suffer from heartburn					
My digestive system is regular (at least 1 bowel movement per day					

Your Mind

	1	2	3	4	5
I manage stress well					
I feel in control of my life (work and family)					
I have the support of my family and friends to lead a healthy lifestyle					
I get 7-8 hours of sleep a night					
I wake up feeling rested and refreshed					
I am interested in learning more about health and wellness					
I am a happy and positive person					
I participate in mind-body activities regularly (meditation, tai-chi or yoga)					
I make time for myself					
I feel positive about my future					

WHAT DO YOU KNOW ABOUT CHIROPRACTIC?

In your own words, what do chiropractors do?

Do any of your friends or relatives see chiropractors?

- Yes
- No

If Yes, do they use chiropractic for:

- Health Improvement & Maintenance
- Health Problems
- Both

Are you seeking chiropractic care for:

Health Improvement & Maintenance

Health Problems

Both

What do you expect from chiropractic care?

Is there anything else that you would like us to know about you?

Yes

No

If Yes, please tell us:

Not enough time to read all the latest news about health and wellness? We make it easy to stay current with our free biweekly newsletter.

Sign me up please!

Yes No