santē | chiropractic wellness
where healthy people go

SANTECHIROPRACTIC.COM
1-1224 PROM. PLACE D'ORLEANS DR. OTTAWA ON K1C 7K3
TEL 613-837-2883 FAX 613-837-4189

CHIROPRACTIC 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? _____

What Brings You To The Clinic?

What area(s) of your body are bothering you the most? *(Check all that apply)*

☐ Back or Neck Pain
☐ Headaches
☐ Shoulder, Elbow, or Wrist Pain
☐ Knee, Hip, or Ankle Pain
☐ Muscle Aches or Pains
☐ Fatigue
☐ Digestive Issues
☐ Cardiovascular / Blood Pressure Issues
☐ Blood Sugar Issues / Diabetes
☐ Hormone Imbalance
☐ Other _____

Symptom History

How long has this problem been going on?

☐ Just started
☐ A few days
☐ A few weeks
☐ A few months
☐ A year or longer

How often are your symptoms present?

☐ Rare
☐ Intermittent
☐ Occasional but daily
☐ Frequent (most days)
☐ Constant

How would you describe the intensity?

☐ Mild
☐ Annoying
☐ Moderate
☐ Getting worse
☐ Intense

Do your symptoms interfere with daily activities?

☐ No
☐ Occasionally
☐ Some activities are limited
☐ Most activities are limited
☐ Extremely limited

Previous Care & Treatment

Who have you seen for this concern or goal? *(Check all that apply)*

☐ Primary Care Physician
☐ Physiotherapist
☐ Massage Therapist
☐ Medical Specialist
☐ Other Health Care Practitioner: _____
☐ Self-treated
☐ Have not sought care yet

What was the outcome?

☐ No improvement
☐ Slight or temporary improvement
☐ ~25% improvement
☐ ~50% improvement
☐ ~75% improvement

Key Health Context *(This helps us understand how your body is functioning overall)*

Sleep

☐ Sleep well (7–8 hours)
☐ Sleep OK (6–7 hours)
☐ Trouble falling asleep
☐ Wake during the night
☐ Poor sleep/sleep deprived

Energy

☐ Great energy all day
☐ Good energy, could improve
☐ Afternoon energy dips
☐ Energy fluctuates, often low
☐ Low energy/fatigue, rely on stimulants

Immunity

☐ Rarely sick
☐ Occasionally sick, recover quickly
☐ Get sick when stressed or run down
☐ Often sick, slow recovery
☐ Catch most illnesses

Mind & Emotions

☐ No concerns
☐ Mild mood changes
☐ Brain fog and/or anxiety
☐ Memory or focus issues
☐ Frequent mood or emotional changes

Weight

☐ At ideal weight
☐ About 10 lbs over/under
☐ Hard to maintain weight
☐ Very hard to lose weight
☐ Significantly overweight

Lifestyle Habits *(Risk factors & recovery capacity)*

Exercise

☐ Daily
☐ 4–5x per week
☐ 3x per week
☐ 1–2x per week
☐ Rarely / sedentary

Hydration

☐ 8–10 glasses of water per day
☐ 6–7 glasses of water per day
☐ 4–5 glasses of water per day
☐ 1–3 glasses of water per day
☐ Mostly coffee or tea

Nutrition

☐ 80–100% whole foods
☐ 60–80% whole foods
☐ About 50% whole foods
☐ Minimal whole foods
☐ Frequent cravings / processed foods

General Health History *(Past injuries can affect current health)*

☐ Falls / Accidents
☐ Sports Injuries
☐ Head Injuries / Concussions
☐ Broken Bones
☐ Knocked Unconscious
☐ Car Accidents
☐ Surgery
☐ Joint Replacement
☐ Stroke
☐ 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 heel lifts? ☐ Yes ☐ No

Have you had X-rays? ☐ Neck ☐ Back ☐ Neither

If yes, where and when?

Nervous System Review

Your spine protects your nervous system, which helps regulate and coordinate every function in your body. Different areas of the spine are connected to different regions and systems. Checking these symptoms helps us understand how your nervous system may be influencing your overall health.

Cervical (Neck)
☐ Headaches ☐ Migraines ☐ Dizziness ☐ Anxiety ☐ Insomnia ☐ Vision issues
☐ Ringing in ears ☐ Sinus issues ☐ Memory or fatigue

Upper Thoracic
☐ Chest tightness ☐ Breathing difficulty ☐ Cough ☐ Blood pressure issues ☐ Numbness in hands ☐ Bloating

Mid Thoracic
☐ Appetite changes ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Blood sugar issues
☐ Immune concerns

Lower Thoracic
☐ Allergies ☐ Digestive discomfort after meals ☐ Kidney or bladder concerns ☐ Swollen ankles
☐ Dizziness on standing

Lumbar / Pelvic
☐ Low back pain ☐ IBS ☐ Bowel issues ☐ Urinary discomfort ☐ Hormonal or reproductive issues ☐ Varicose veins

Chiropractic Care

Your primary reason for seeking chiropractic care is

☐ To address a specific health concern or symptom
☐ To support overall health, function, and resilience
☐ A combination of both

Have you received chiropractic care in the past? ☐ Yes ☐ No

If yes, how would you describe your experience?

☐ Very helpful / productive
☐ Somewhat helpful
☐ Not helpful
☐ Unsure / mixed experience

If you stopped chiropractic care in the past, what was the main reason? *(Check all that apply)*

☐ My concern improved / I felt better
☐ I did not notice enough improvement
☐ Scheduling or time constraints
☐ Cost or insurance coverage
☐ I moved or changed providers
☐ I was unsure of the plan or next steps
☐ Other: _____

Your Health Goals

We want to make sure we focus on what matters most to you.

If you had a magic wand, what 3 health issues would you most like to improve?

1.
2.
3.

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

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 CHIROPRACTIC NEW PATIENT HEALTH QUESTIONNAIRE! We look forward to helping you with your current health concerns and overall well-being.