



santé | chiropractic
wellness

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 #



HOW DID YOU HEAR ABOUT OUR OFFICE?

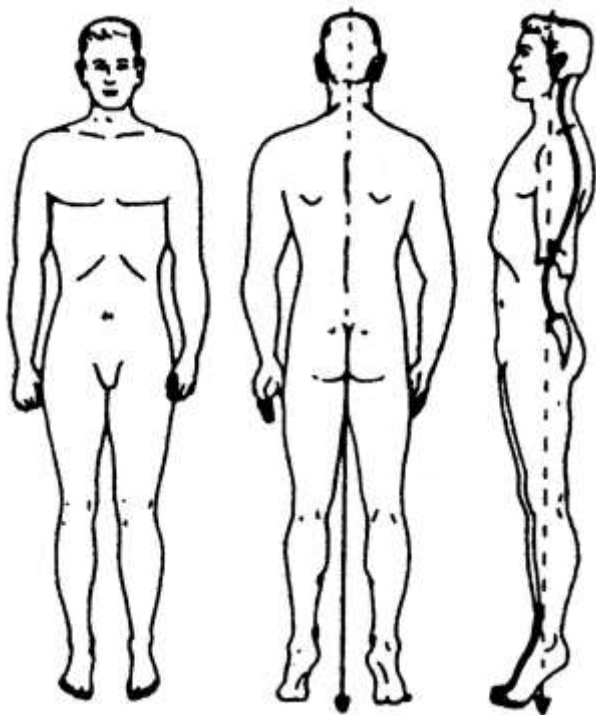
Please Check One:

- Family Member
- Friend
- Internet Search
- 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 TO THE CLINIC?

Where is/are the problem(s)? 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
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 specialty:

GENERAL HEALTH HISTORY

Past injuries can affect present health.

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Falls/Accidents | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Head Injuries/Concussions | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Car Accidents |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> 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 ever had X-rays taken of you:

- 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

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

Upper Thoracic Nerves

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

Mid Thoracic Nerves

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Gastric Ulcer |
| <input type="checkbox"/> Crave Sweets | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Vomiting Food | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Immune Deficiencies | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Black Stool | <input type="checkbox"/> Hypoglycemia |

Lower Thoracic Nerves

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> Digestive Complaints after Eating |
| <input type="checkbox"/> Appendix Problems | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Testicular or Ovarian Problems |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Dizziness upon Standing | |

Lumbar Nerves

- | | | |
|--|--|---|
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> IBS | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Dark Circles under Eyes | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Reproductive Disorders |
| <input type="checkbox"/> Female Problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I regularly track my personal health measures such as weight and blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am happy with my body composition (muscle mass vs fat mass)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get at least 30 minutes of moderate aerobic activity 3 to 4 days per week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I participate in strength training exercises at least twice per week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with my level of energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to complete my activities of daily living with little or no difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I stretch 2 to 3 times per week or after work-outs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I have a strong core with no or very little back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am happy with my current level of fitness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Your Nutrition:

	1	2	3	4	5
I think my diet is well balanced	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I eat at least 8-10 servings of fruits and/or vegetables a day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I drink 8-10 cups of water a day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am aware that certain foods affect the way I feel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I pay attention to the amount of food I eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I avoid high sugar content foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I avoid highly processed/fast foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We mostly prepare our own food at home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't suffer from heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My digestive system is regular (at least 1 bowel movement per day)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Your Mind:

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

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:

- Better Health & Maintenance
- Health Problems
- Both

Are you seeking chiropractic care for?

- Health Improvement & Maintenance
- Health Problems
- Both

What do you expect from chiropractic care?

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

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

- Yes
- No

If Yes, please tell us:

**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!**

The team at Santé Chiropractic and Wellness Centre