santē | 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 #

Email:

Work Phone #

HOW DID YOU HEAR ABOUT OUR OFFICE?

Please Check One:

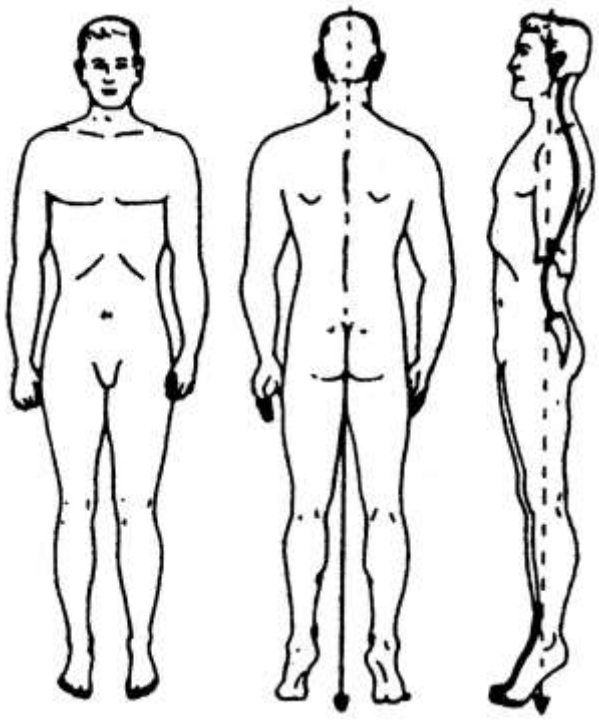
- ☐ Family Member
- ☐ Friend
- ☐ Internet Search
- ☐ Health Care Professional (eg. Physician, Physiotherapist, Massage Therapist etc.)
- ☐ Other (Please Specify): _____

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
	○	○	○	○	○	○	○	○	○	○

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:

- ☐ 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 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?

If Yes, please describe:

- ◯ Yes
- ◯ No

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

Upper Thoracic Nerves

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

Mid Thoracic Nerves

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

Lower Thoracic Nerves

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

Lumbar Nerves

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

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 8-10servings of fruits and/or vegetables a day	○	○	○	○	○
I drink 8-10 cups of water a day	○	○	○	○	○
I am aware that certain foods affect the way I feel	○	○	○	○	○
I pay attention to the amount of food I eat	○	○	○	○	○
I avoid high sugar content foods	○	○	○	○	○
I avoid highly processed/fast foods	○	○	○	○	○
We mostly prepare our own food at home	○	○	○	○	○
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:

☐ 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 want, 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