Chiropractic Welcome Back Health Update Questionnaire

It's been a while since your last visit and we want to make sure that we are up to date on your health and wellness needs. Please take a moment to complete this short questionnaire so that we can update our files.

Name

Date

E-mail

CONTACT INFORMATION

My contact info has not changed

☐

Address

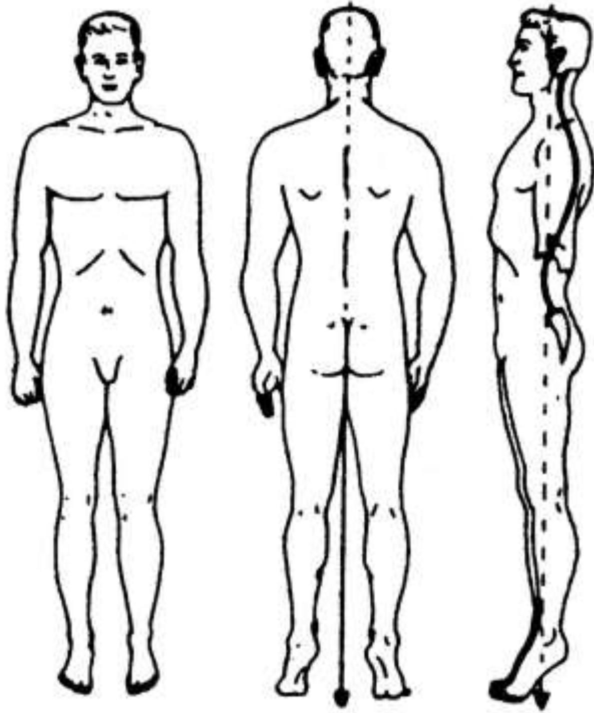
City, Province, Postal Code

Home/Cell Phone #

Work Phone #

WHAT BRINGS YOU BACK TODAY?

Where is/are the problem(s)? Please use the diagram and lines 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
- ☐ 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 currently 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
- ☐ 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
- ☐ 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

Have there been any other changes to your health that we should know about?

○ Yes ○ No

If Yes, please describe:

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

Thank you for filling out our Chiropractic Welcome Back Health Questionnaire. We look forward to helping you with your health concerns and overall well-being!

The Team at Santé Chiropractic and Wellness Centre