Low-Level Laser & PEMF New Patient Health Questionnaire

santē | chiropractic wellness

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:

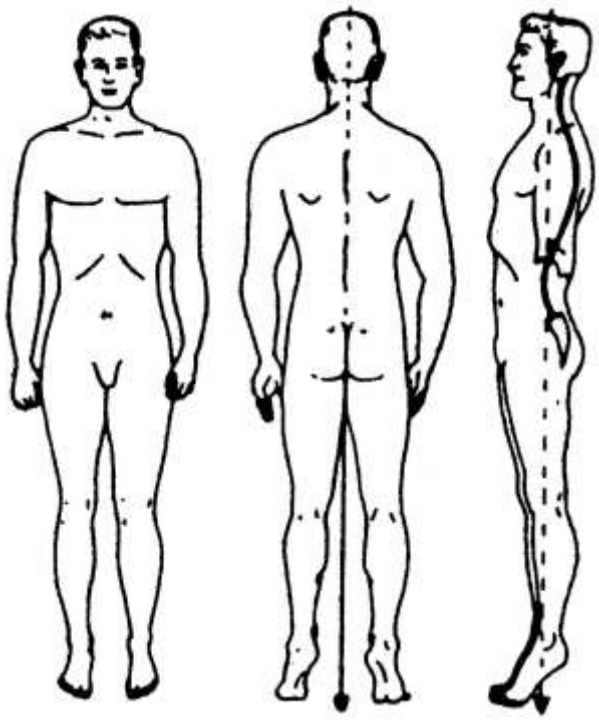
- ☐ Family Member
- ☐ Friend
- ☐ Internet Search
- ☐ Health Care Professional (eg. Physician, Physiotherapist, Massage Therapist etc.)
- ☐ Other (Please Specify): _____

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
	○	○	○	○	○	○	○	○	○	○

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 have any other health concerns we should know about?

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 Low-Level Laser & PEMF 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