Patient Information

Date _____

Please complete the following questionnaire. It will help determine if Chiropractic care can help you (please print).

First name(s) _____ Last name _____

Address _____

Phone (h) _____ (w) _____ (m) _____

Email _____ Occupation _____

Date of birth _____ Age _____ Height _____ Weight _____

○ Married ○ Partnered ○ Single ○ Widowed ○ Separated ○ Divorced

In case of emergency, contact

Name _____ Relationship _____ Contact number _____

Who may we thank for referring you? _____

How can we help you?

What brings you in today? _____

If you are experiencing symptoms, what are they? _____

Onset date: Original _____ Recent _____ How was it caused? _____

Previous treatment by: _____ Result _____

Is there a family history of this problem? ○ Yes ○ No

Is your problem aggravated by or related to your work? ○ Yes ○ No

Is your sleep restful? ○ Yes ○ No

Do you sleep on ○ Side ○ Back ○ Stomach ○ Combination

How old is your mattress? _____ years

Does your mattress still support you? ○ Yes ○ No

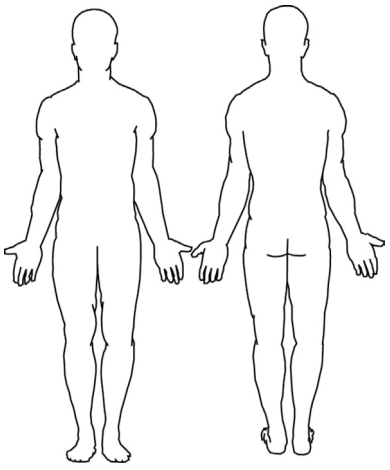
How many pillows? _____

How intense are your symptoms? (circle ○)

❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NO SYMPTOMS — INTENSE SYMPTOMS

Please **circle areas** on the diagrams where you have **pain** or other **symptoms**



FRONT BACK

What does it feel like? (tick ☑)

○ Numbness	○ Sharp
○ Tingling	○ Shooting
○ Stiffness	○ Burning
○ Dull	○ Throbbing
○ Aching	○ Stabbing
○ Cramping	○ Swelling
○ Nagging	○ Other _____

Impact of your symptoms

How is this symptom/condition interfering with your life? (tick ☑)

	No Impact	Mild Impact	Moderate Impact	Severe Impact
Work	○	○	○	○
Exercise	○	○	○	○
Recreation	○	○	○	○
Relationships	○	○	○	○
Sleep	○	○	○	○
Diet	○	○	○	○

	No Impact	Mild Impact	Moderate Impact	Severe Impact
Energy	○	○	○	○
Attitude	○	○	○	○
Patience	○	○	○	○
Productivity	○	○	○	○
Stress	○	○	○	○
Other _____	○	○	○	○

How committed are you to correcting this issue? (circle ○)

❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NOT COMMITTED — VERY COMMITTED

A bit about you

How many children do you have? _____

Are you currently pregnant? ○ No ○ Yes, due: _____

Children's ages _____

Number of past pregnancies _____

Children's health concerns _____

Health concerns regarding this pregnancy _____

Health and illness history

Please tick ☑ the box beside any condition that you have, either current or previously

- ○ AIDS/HIV
- ○ Alcoholism
- ○ Anxiety
- ○ Arteriosclerosis
- ○ Arthritis
- ○ Asthma/Allergies
- ○ Back Pain
- ○ Cancer
- ○ Celiac Issues
- ○ Childhood Illness
- ○ Depression
- ○ Diabetes
- ○ Digestive Issues
- ○ Elbow/Wrist/Hand Issues
- ○ Endocrine Issues (Thyroid)
- ○ Foot/Ankle Issues
- ○ Headaches/Migraines
- ○ Heart Disease
- ○ Hepatitis
- ○ Hip Issues
- ○ Immune Issues
- ○ Jaw Issues
- ○ Lymphatic Issues
- ○ Neck Pain
- ○ Osteoporosis
- ○ Reproductive Issues
- ○ Ringing in Ears
- ○ Scoliosis/Spinal Curvature
- ○ Shoulder Issues
- ○ Stress
- ○ Stroke
- ○ Urinary Issues
- ○ Vertigo
- ○ Other _____

Allergies, medications & supplements

Allergies (list)	Medications (list)	Supplements (list)

What are your health goals?

Immediate _____

Short term _____

Long term _____