NORWOOD CHIROPRACTIC

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NEW PATIENT QUESTIONNAIRE

Welcome to our clinic! These forms will give us a better understanding of your health history and current complaints. Please fill them out as accurately as possible. If you need assistance or have any questions, please speak with the receptionist.

NAME: _____ DATE: _____

DATE OF BIRTH: year _____ month _____ day ____ AGE:____ SEX: male / female

MAILING ADDRESS: _____

_____

TELEPHONE (home): _____ (work): _____

EMAIL ADDRESS FOR APPOINTMENT REMINDERS:_____

EMPLOYER: _____

OCCUPATION / TYPE OF WORK: _____

MEDICAL DOCTOR: _____ LOCATION: _____

Who may we thank for referring you to this office? _____

Have you ever had any of the following treatments before? (please circle yes or no)

- Chiropractic? Yes No

  If yes, Doctor's name and approximate date of last visit: _____
- Massage Therapy? Yes No
- Acupuncture? Yes No
- Physiotherapy? Yes No

Is your complaint the result of an accident at work? Yes No

Is it a worker's compensation (WSIB) claim? Yes No

(If yes, please see the receptionist for additional forms.)

Is your complaint a result of a motor vehicle accident? Yes No

(If yes, please see the receptionist for additional forms.)

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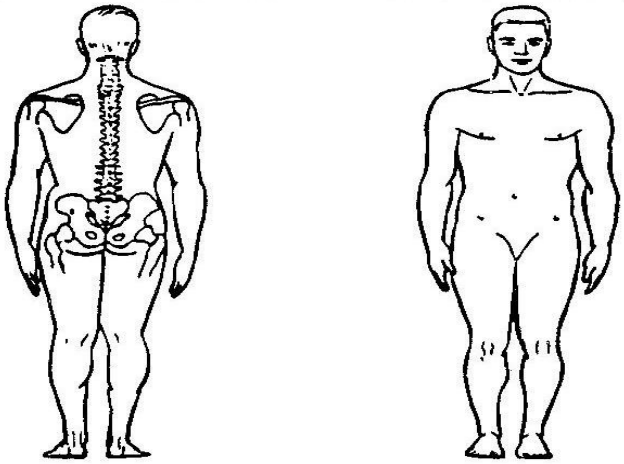
IF YOU ARE IN PAIN, PLEASE MARK THE LOCATION ON THE DIAGRAMS BELOW:



MAJOR COMPLAINT: WHAT TYPE OF PAIN? _____

HOW OFTEN? _____

HOW DID YOUR CONDITION START? _____

_____

_____

HOW HAS THIS CONDITION AFFECTED YOUR QUALITY OF LIFE? (home/work/sleep, etc.)

_____

_____

_____

HAVE YOU EVER HAD ANY TREATMENT FOR THIS CONDITION? _____

_____

HAVE YOU EVER HAD ANY SURGERY? Yes / No If yes, for what?, when? _____

_____

_____

DO YOU TAKE ANY MEDICATIONS OR VITAMINS? If yes, list all _____

_____

_____

DO YOU CURRENTLY SMOKE? Yes / No

HAVE YOU EVER BEEN IN A CAR ACCIDENT? Yes / No If yes, when?, any injuries?

_____

_____

HAVE YOU EVER HAD ANY FRACTURES? Yes / No If yes, where?, when?

_____

_____

Name: _____ Date: _____

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SYMPTOMS: PAST AND PRESENT

Please circle any conditions or symptoms that presently cause you problems. Please check ( ) any conditions or symptoms which have been a problem to you in the past.

GENERAL SYMPTOMS
Loss of consciousness
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Loss of sleep
Numbness or tingling
Nervousness
Anxiety
Depression
Insomnia

MUSCLES & JOINTS
Stiff neck
Back pain
Shoulder pain
Elbow pain
Wrist pain
Hand/finger pain
Hip pain
Knee pain
Ankle/foot pain
Jaw pain
Arthritis
Swollen joints
Weakness/loss of strength
Fibromyalgia

E.E.N.T.
Vision problems
Eye pain
Deafness
Earache
Plugged ears
Ringing/buzzing in ears
Frequent colds
Sinus problems
Enlarged glands
Enlarged thyroid
Underactive thyroid
Overactive thyroid

RESPIRATORY
Asthma
Difficulty breathing
Chronic cough
Spitting up phlegm
Spitting up blood

CARDIOVASCULAR
Chest pain
Angina
Stroke
High blood pressure
High cholesterol
Heart disease
Heart attack
Bleeding disorder
Poor circulation
Varicose veins
Phlebitis
Swelling of ankles
Anemia

GENITOURINARY
Trouble urinating
Pain with urination
Blood in urine
Kidney infection
Bladder infection
Enlarged prostate
Prostate cancer

FOR WOMEN ONLY
Painful menstruation
Irregular cycle
Heavy bleeding
Vaginal discharge
Recurrent yeast infection
Hot flashes/night sweats
Swollen/tender breasts
Lumps in breast
Breast cancer
Are you currently taking birth control pills? YES / NO
Number of pregnancies ___
Number of children ___

SKIN
Rashes/itching
Bruise easily
Dryness
Boils
Allergic hives

GASTROINTESTINAL
Poor appetite
Excessive hunger
Indigestion
Heartburn
Ulcer
Nausea
Vomiting
Constipation
Diarrhea
Crohn's disease
Diverticulitis
Irritable bowel syndrome
Inflammatory bowel disease
Pain over stomach
Hemorrhoids
Jaundice
Gall bladder problems
Diabetes

NEUROLOGICAL
Bell's Palsy
Epilepsy / Seizures
Multiple Sclerosis
Parkinson's Disease
Tremors

PLEASE LIST ANY OTHER KNOWN MEDICAL CONDITIONS NOT MENTIONED ABOVE.

_____
_____
_____
_____
_____
_____
_____

Name: _____ Date: _____