

# PATIENT QUESTIONNAIRE CLOVERDALE CHIROPRACTIC CLINIC

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Address \_\_\_\_\_ Apt./Unit# \_\_\_\_\_  
City: \_\_\_\_\_ Province \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone#, Home: (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_ Bus: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Email Address: \_\_\_\_\_

(We respect the privacy of our patients. Emails are for office information and correspondence only)

Check one: \_\_ Single \_\_ Married \_\_ Widowed \_\_ Divorced \_\_ Separated

Spouse's Name \_\_\_\_\_ # of children \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check the type of care you are seeking:

Correction \_\_\_\_\_ Relief Care \_\_\_\_\_ Wellness \_\_\_\_\_

## YOUR HEALTH PROFILE

Please briefly describe what brings you into our office today: \_\_\_\_\_

Severity of symptoms - Scale 1-10 (1 being mild) \_\_\_\_\_ Symptoms are: Constant \_\_\_\_\_ Intermittent \_\_\_\_\_

When and how did this start? \_\_\_\_\_

Since the problem started it is: The same \_\_\_\_\_ Getting Better \_\_\_\_\_ Getting Worse \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

What if anything makes the problem feel better? \_\_\_\_\_

Who have you seen for this condition? Chiropractor \_\_\_\_\_ M.D. \_\_\_\_\_ Physio \_\_\_\_\_ Other \_\_\_\_\_

Name(s) and approximately when? \_\_\_\_\_

Over the past 90 days has the pain or dysfunction limited your ability to?

Lift heavy objects \_\_\_\_\_ Stand \_\_\_\_\_ Sit \_\_\_\_\_ Walk \_\_\_\_\_ Drive \_\_\_\_\_ Socialize \_\_\_\_\_ Exercise/Sports \_\_\_\_\_

Have you had this or similar conditions before? Yes \_\_\_\_\_, When? \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

## GENERAL HEALTH HISTORY

Please list all current and past significant health conditions, diseases and injuries, as well as past surgeries \_\_\_\_\_

Have you had chiropractic care in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when /where \_\_\_\_\_

For what condition? \_\_\_\_\_ Were x-rays taken? Yes \_\_\_\_\_ No \_\_\_\_\_

Your Medical Doctor's name: \_\_\_\_\_ Date of last Physical Examination \_\_\_\_\_

List any medications you are currently taking, and why \_\_\_\_\_

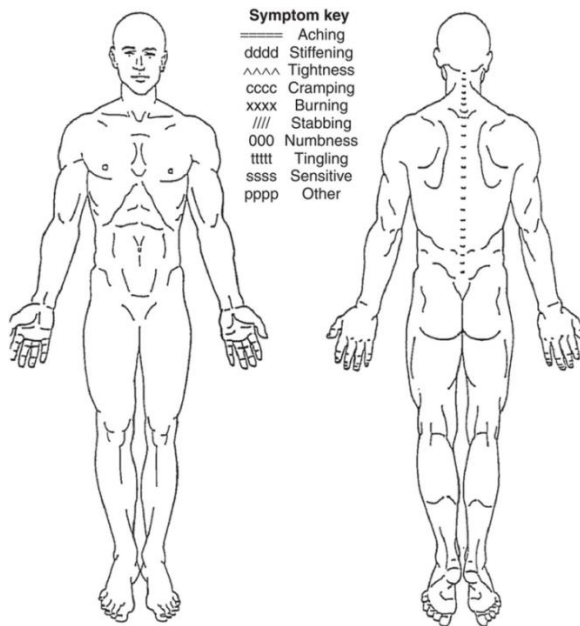
Have you ever been hospitalized? Explain \_\_\_\_\_

Have you ever been knocked unconscious? Yes \_\_\_ No \_\_\_ Don't Know \_\_, If yes, for how long? \_\_\_\_\_

Have you ever been in an automobile accident? Explain \_\_\_\_\_

Women: Are you pregnant? Yes \_\_\_ No \_\_\_ Not sure \_\_ Type of birth control used \_\_\_\_\_

**MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW**



Do you have or have been treated for any of the following conditions? Please check all that apply:

Allergies	Headaches
Arthritis	Heart Trouble
Asthma	Loss of balance
Backaches	Loss of Memory
Chest pain	Loss of Smell/Taste
Cold Hands	Neck Pain
Cold hands	Nervousness
Cold sweats	Neuritis
Constipation/ diarrhea	Pins and Needles
Depression	Shortness of Breath
Depression	Sinus trouble
Diabetes	Sleeping Disorders
Dizziness	Stress
Fainting	Tension
Fatigue	Tinnitus

**AN IMPORTANT COMPONENT OF CARE IS REGULAR REASSESSMENT, PLEASE RATE THE FOLLOWING:**

Your overall quality of life	low	1	2	3	4	5	6	7	8	9	10	high
Your mood	low	1	2	3	4	5	6	7	8	9	10	high
Your energy	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to move	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to do household activities	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to do recreational activities	low	1	2	3	4	5	6	7	8	9	10	high

# YOUR STRESS PROFILE

## 1. PHYSICAL STRESSES

Have you had work related injuries?  No  Yes: Briefly explain \_\_\_\_\_

Have you had sports related injuries?  No  Yes Briefly explain \_\_\_\_\_

Have you had slips, falls or auto accidents?  No  Yes Briefly explain \_\_\_\_\_

## 2. EMOTIONAL PSYCHOLOGICAL STRESSES On a scale of 1 to 10 (1 is low, 10 is extreme)

\_\_\_/10 Occupational/School stresses: \_\_\_\_\_

\_\_\_/10 Family/Relationship stresses: \_\_\_\_\_

\_\_\_/10 Other stresses (i.e. Financial): \_\_\_\_\_

## 3. NUTRITIONAL CHEMICAL STRESSES On a scale of 1 to 10 (1 is poor, 10 is excellent)

Water \_\_\_/10, Proteins \_\_\_/10, Healthy Fats \_\_\_/10, Fruits/Vegetables \_\_\_/10

Is your diet high in: sugar  Unhealthy snacks \_\_\_ Soda \_\_\_ Processed foods \_\_\_ Coffee \_\_\_

Which of the following supplements do you take regularly: Omega 3 \_\_\_ Vit. D \_\_\_ Probiotics \_\_\_

Do you wear orthotics \_\_\_ arch supports \_\_\_ heel lifts \_\_\_

List other supplements you take regularly \_\_\_\_\_

Rate the following: Exercise \_\_\_/10 Sleep \_\_\_/10 Positive Attitude \_\_\_/10 Wellness lifestyle \_\_\_/10

**Please let us know if there are any health related issues that concern you, aside from the main problem that you are coming here for** \_\_\_\_\_

## FAMILY HISTORY:

Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please list any family member who has or had any health problems.

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