Back in Balance
A centre for wellbeing

New Chiropractic Patient Confidential Health Questionnaire

Your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: _____ Date: _____
Date of Birth: _____ Age: ____ Gender: ☐ Male ☐ Female ☐ Non-Binary
Address: _____ Apt. #: _____
City: _____ Province: _____ Postal Code: _____
Home Tel: _____ Work Tel: _____ Cell Tel: _____
Email address: _____ Occupation: _____
Please indicate your reminder preference: ☐ ***email*** ☐ ***phone call*** ☐ ***text*** ***If text, indicate cell carrier:*** _____
Would you like to subscribe to our monthly newsletter for stretches, chiropractic tips, and recipes? ☐ Yes ☐ No
In case of emergency contact_____ Relationship_____ Contact tel. _____
Names and ages of dependent children: _____
Whom may we thank for recommending this practice? _____

Will a claim be made against: 1) Motor Vehicle Accident ☐ Yes ☐ No 2) Work Related Injury ☐ Yes ☐ No
Please complete if you answered YES to a work related injury: What is your social insurance number: _____
WSIB Claim number: _____ Date of accident: _____ Employers name: _____

Medical Doctor:
Medical Doctor Name: _____ Clinic Name: _____
Address: _____ Phone number: _____ Date of last physical: _____
May we contact your M.D. to provide him/her with documentation regarding your case? ☐ Yes ☐ No

Previous Chiropractic Experience:
Have you had previous chiropractic experience? ☐ Yes ☐ No Previous Chiropractor Name: _____
Telephone: _____ Date of last visit: _____ X-rays taken? ☐ Yes ☐ No

Medical History:
Have you been previously hospitalized? ☐ Yes ☐ No If yes, indicate reason: _____
List any previous surgeries: _____
List any falls or accidents: _____
List any motor vehicle accidents: _____
Are you taking any medications or drugs? ☐ Yes ☐ No Please list:
_____

List any family health problems:
Maternal:_____
Paternal:_____

Women Only: Is your menstrual cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No
Are you using birth control pills / patch / injections? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____ Due date: _____ Nursing? ☐ Yes ☐ No

Past Health History: Please **CHECK** if you presently have any of the following conditions or symptoms.
Please **CIRCLE** those conditions or symptoms which have been a problem to you in the past.

☐ Arthritis	☐ Diarrhea	☐ Heart Condition	☐ Kidney infection
☐ Allergies	☐ Difficulty breathing	☐ Headaches	☐ Loss of weight
☐ Asthma	☐ Dizziness	☐ Hepatitis	☐ Nausea
☐ Aneurysm	☐ Chronic cough	☐ Hernia	☐ Osteoporosis
☐ Blurred vision	☐ Chest Pain	☐ High/low blood pressure	☐ Polio
☐ Cancer	☐ Fever	☐ HIV	☐ Rashes
☐ Constipation	☐ Fibromyalgia	☐ Respiratory Condition	
☐ Sinus Conditions	☐ Stroke	☐ Other: _____	
☐ Vomiting	☐ Trouble urinating	_____	

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Name: _____ **Date:**_____

Chief complaint or area of pain: _____
How long have you had this problem?_____
Do you know how the problem began? (**sudden** – fall, accident, etc, / **gradual** / **chronic**)
_____
What makes the problem worse? _____
What makes the problem better? _____
Is the problem: ☐ Mild ☐ Moderate ☐ Severe Rate you pain on a scale of 0 - 10: _____
Does the pain travel anywhere? _____
Is the problem: ☐ Intermittent ☐ Constant How long does it last? _____
Does it occur mostly during the: ☐ Day ☐ Night ☐ Both

Does it interfere with your:
☐ Work related duties _____
☐ Sleep _____
☐ Daily routines _____

Lifestyle
Do you smoke? ☐ Yes ☐ No For how long? _____ How much? _____
Do you consume alcohol? ☐ Yes ☐ No How much? _____
How do you rate your sleep? ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
How many hours of sleep do you get per night? _____ Do you wake feeling rested? ☐ Yes ☐ No
List any stress: _____
How many meals do you eat per day? ____
How do you rate your diet? ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
List any vitamins / minerals you are currently taking: _____

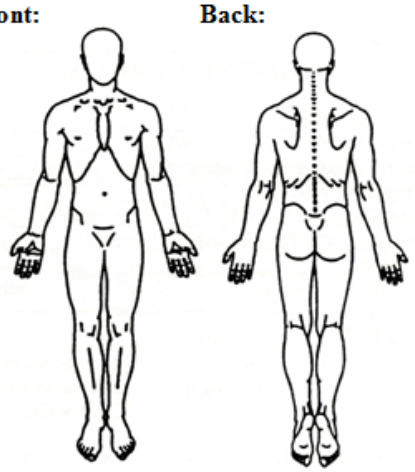
What are your expectations of chiropractic care at this office? _____
Please select the health goals that you would like us to help you achieve:
☐ **Initial Intensive Care –** focusing on pain control and relief of symptoms
☐ **Corrective Care –** restoring optimal motion, strength, and function
☐ **Maintenance Care –** regular care to correct minor problems and improve health
☐ **Other:** _____

In the diagram below, please mark the areas on your body which best represents your chief complaint

Symbols:

Numbness	≡≡≡	Pins & Needles	• • • • • •
Burning	x x x x x x	Stabbing & Sharp	//////
Dull & Aching	+ + + + + +	Stiff & Tight	2 2 2 2 2 2

Front: **Back:**



Your signature: _____ **Date:** _____
Please initial to confirm that you have read our office fees and policies: _____