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.

Legal Name: _____ Date: _____
If under 18, Parent/Guardian Name(s): _____
Preferred Name: _____ Date of Birth: _____ Age: _____
Gender: ☐ Male ☐ Female ☐ Other: _____ Preferred Pronouns _____
Address: _____ Apt. #: _____
City: _____ Province: _____ Postal Code: _____
Home Tel: _____ Work Tel: _____ Cell Tel: _____
Email Address: _____ Occupation: _____
Please indicate your reminder preference: ☐ ***Email*** ☐ ***Text*** ☐ ***Both*** ***If text, indicate cell carrier:*** _____
Emergency Contact Name: _____ Relationship_____ Contact Tel: _____
Names and ages of dependent children: _____
How did you hear about us? _____

We do not direct bill to MVA/WSIB. Please see the reception for more information.

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

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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 your 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: _____

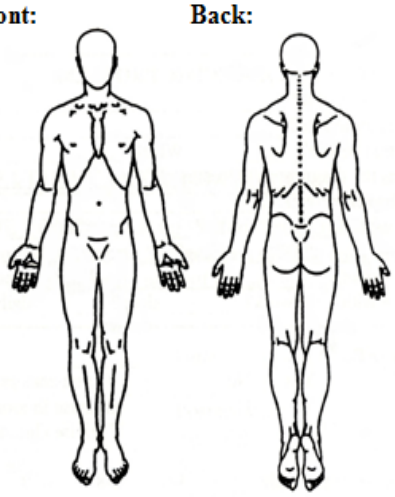
What are your expectations of chiropractic care at this office? _____
Please select the health goals that you would like us to help you achieve:
☐ **Initial Intensive Care –** focusing on pain control and relief of symptoms
☐ **Corrective Care –** restoring optimal motion, strength, and function
☐ **Maintenance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

In the diagram below, please mark the areas on your body which best represent 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:** _____

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Please complete the following section for children ages 10 and under only:

Name of Pediatrician: _____
Date of last visit: _____ Reason for visit: _____
Other health concerns? _____

Check any of the following conditions that may apply to your child:

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic Colds
□ Headaches	□ Asthma/Allergies	□ Digestive Problems	□ ADHD
□ Recurring Fevers	□ Growing/Back Pains	□ Colic	□ Bed Wetting
□ Temper Tantrums	□ Car Accident	□ Other: _____	

Prenatal History:
Location of birth: □ Home □ Birthing Center ■ Hospital
Complications during pregnancy? □ No □ Yes If yes, please list _____
Birth interventions?
□ Induction □ Artificial rupture of membranes □ Forceps □ Vacuum extraction □ C-section, ER or planned
Complications during Labor/Delivery? □ No □ Yes If yes, please list _____
Genetic Disorders/Anomalies? □ No □ Yes If yes, please list _____

Feeding History:
Breastfed? □ Yes □ No How long?_____
Formula fed? □ Yes □ No How long? _____
Introduced to solid food at what age?_____
Cow's milk at what age?_____
Food/juice allergies/intolerances □ No □ Yes If yes, please list_____

Sleep Posture:
□ Right side □ Left side □ Back □ Stomach

Developmental History:
Is/has your child been involved in any high-impact or contact sports (i.e. soccer, football, gymnastics, basketball, baseball, cheerleading, martial arts, etc.)? □ No □ Yes If yes, please list_____

Parent/Guardian signature: _____

Date: _____

Thank you for choosing Back in Balance for your wellness care.