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

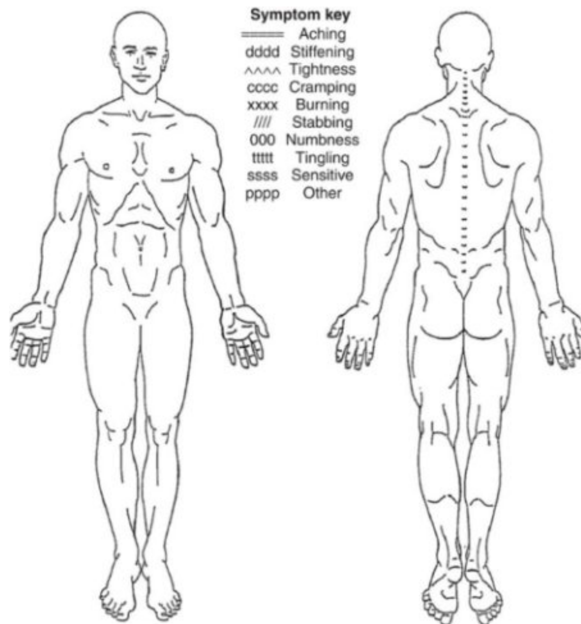
Please briefly describe what brings you into our office today: ____________________________________
____
Severity of symptoms - Scale 1-10 (1 being mild) ____Symptoms are: Constant____ Intermittent_____
When and how did this start? ____
Since the problem started it is: The same______ Getting Better______ 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
Arthritis
Asthma
Backaches
Chest pain
Cold Hands
Cold hands
Cold sweats
Constipation/ diarrhea
Depression
Depression
Diabetes
Dizziness
Fainting
Fatigue
Headaches
Heart Trouble
Loss of balance
Loss of Memory
Loss of Smell/Taste
Neck Pain
Nervousness
Neuritis
Pins and Needles
Shortness of Breath
Sinus trouble
Sleeping Disorders
Stress
Tension
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 t0 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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