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New Patient Questionnaire

NAME: _____ DATE OF BIRTH _____

ADDRESS: _____ POSTAL CODE: _____

HOME PHONE: _____ BUSINESS PHONE: _____

AGE: ____ HEIGHT: ____ WEIGHT: ____ SHOE SIZE: ____DO YOU WEAR ORTHOTICS? YES___ NO____

OF CHILDREN: _____ MARITAL STATUS: M S W D EMAIL ADDRESS:_____

EMPLOYER: _____ OCCUPATION:_____

MEDICAL DOCTOR:_____

WHO REFERRED YOU TO THIS CLINIC: _____

WHERE IS YOUR MAJOR COMPLAINT: _____

WHEN DID YOU FIRST NOTICE THE SYMPTOMS? _____

HAS THIS HAPPENED BEFORE? _____ WHEN? _____

DOES THIS INTERFERE WITH YOUR NORMAL LIVING AND WORK? _____

IS THERE A FAMILY HISTORY OF THIS CONDITION? _____ WHO? _____

ARE THERE ANY SECONDARY PROBLEMS? _____ WHAT?_____

ANY FALLS, ACCIDENTS, FRACTURES ETC.? _____ WHEN? _____

DO YOU SMOKE? _____ DO YOU EXERCISE? _____ HOW OFTEN? _____

DO YOU TAKE ANY MEDICATION? _____ WHAT? _____

DO YOU TAKE VITAMINS? _____ WHAT? _____

HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? YES___ NO ___

IF YES, WHO? _____ WHEN? _____

DATE OF LAST X – RAYS _____ WHERE? _____