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## New Patient Questionnaire

DATE: _____ DATE OF BIRTH: _____

PREFERRED PRONOUN: _____ NAME: _____

ADDRESS: _____ CITY: _____ 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 REFEREED YOU TO THIS CLINIC: _____

WHERE IS YOU MAJOR COMPLAINT: _____

WHEN DID YOU FIRST NOTICE 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 MEDICATIONS? _____ WHAT? _____

DO YOU TAKE VITAMINS? _____ WHAT? _____

HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? YES ____ NO___

IF YES, WHO? _____ WHEN? _____

DATE OF LAST X-RAYS _____ WHERE? _____

I hereby consent to having a complete Chiropractic examination which includes: a History, Physical examination and X-rays if required.

Signature: _____

Date: _____