

# Dr. Shulman and Dr. Houde-Shulman

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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? \_\_\_\_\_

### PLEASE INDICATE PROBLEM AREAS BY CHECKING THE APPROPRIATE BOXES

#### HEAD

- HEADACHES
- DIZZINESS
- SINUS
- OTHER

#### EYES

- GLASSES
- PAIN
- INFLAMMATION
- OTHER

#### EARS

- HEARING TROUBLE
- RINGING
- PAIN
- OTHER

#### NOSE

- HAY FEVER
- COLDS
- OBSTRUCTION
- OTHER

#### NECK

- STIFFNESS
- GRATING
- PAIN
- TENSION
- OTHER

#### SHOULDERS R L

- STIFFNESS \_\_\_\_\_
- BURSITIS \_\_\_\_\_
- PAIN \_\_\_\_\_
- TENSION \_\_\_\_\_
- OTHER \_\_\_\_\_

#### ARMS

- UPPER \_\_\_\_\_
- ELBOWS \_\_\_\_\_
- WRISTS \_\_\_\_\_
- HANDS \_\_\_\_\_
- OTHER \_\_\_\_\_

#### R L

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### LEGS

- HIPS \_\_\_\_\_
- THIGHS \_\_\_\_\_
- KNEES \_\_\_\_\_
- CALVES \_\_\_\_\_
- ANKLES \_\_\_\_\_

#### LOW BACK

- PAIN
- STIFFNESS
- PAIN DOWN LEG
- NUMBNESS
- TINGLING
- OTHER

#### MID-BACK

- PAIN
- STIFFNESS
- RIB PAIN
- TENSION
- OTHER

#### HEART

- PAIN
- SPASM
- PALPITATION
- ATTACK
- OTHER

#### LUNGS

- TUBERCULOSIS
- PAIN AROUND CHEST
- INTERCOSTAL NEURITIS
- OTHER

#### ABDOMEN

- STOMACH
- LIVER
- GALL BLADDER
- KIDNEYS

- INTESTINES
- DIGESTION
- GAS
- CONSTIPATION

- DIARRHEA
- HAEMORRHOIDS
- TENDERNESS
- BLOATING

- MENSTRUAL PAIN
- MENSTRUAL CRAMPS
- MENSTRUAL IRREGULARITY

#### DO YOU HAVE

- INNER TENSION
- NERVOUSNESS
- INSOMNIA
- FAINTING

- WEAKNESS
- ANAEMIA
- DIABETES
- CANCER

- RHEUMATISM
- ARTHRITIS
- GOITER
- NUMBNESS

- SUDDEN WEIGHT LOSS
- STD's
- HIV / AIDS

#### PAIN INDEX

CIRCLE PAINFUL AREAS ON DIAGRAM, MARK AS FOLLOWS:

B BURNING

S STABBING

A ACHE

N NUMBNESS