QUEEN STREET
Chiropractic

259 Queen Street, Kingston, Ontario K7K 1B5
(613) 545-9553

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. I hereby consent to the release of billing/records information to my insurance company upon request.

Signature: _____

Date: _____