PATIENT INFORMATION AND PRE-CONSULTATION QUESTIONNAIRE

Patient Information **Date:**

First Name	Last Name			
Address				
Town/City	Province	Postal Code		
Home Phone	Work Phone			
Cell Phone	Marital Status	Number of Children		
Email				
Birth Date	Sex ☐ M ☐ F	Age	Height	Weight
Occupation	Employed by			
Spouse's Name	Occupation			
How did you hear about our office?				
Were you referred to this office? ☐ Yes ☐ No If so, by whom?				

Health Insurance Information

Do you have Extended Health Insurance? ☐ Yes ☐ No	Amount of coverage per year
If yes, by what company?	

Medical History

What is your major complaint?
How long have you had this condition?
Is this condition getting progressively worse? ☐ Yes ☐ No
What activities aggravate your condition?
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other
Have you seen any other health care professionals for this condition? ☐ Yes ☐ No
If yes, who and when?
Did you receive any treatment?
Have you ever been in a car accident? ☐ Yes ☐ No
If yes, please explain, giving date of accident(s) and description of injuries.
Is your complaint the result of a work injury? ☐ Yes ☐ No
If yes, please explain, giving date of accident(s) and description of injuries.
Do you have any other complaints?

Past Medical History

Family Physician	Phone Number	Date of last examination
Have you been treated by a physician for any condition(s) in the past 12 mo.? ☐ Yes ☐ No		
If yes, please explain		

Please describe:

Past injuries
Prior surgeries
Prior hospitalizations

Circle any conditions that you have now or have experienced in the past.

Sinus trouble	Vision problems	Ear infections	Ringing in the ears/hearing loss	
Anemia	Depression	Insomnia	Tingling/numbness	Fibromyalgia
Dizziness	Tension	Nervousness	Anxiety/panic disorders	
Shortness of breath/difficulty breathing		Arthritis	Urinary tract infections	
Nausea/vomiting	Stomach problems	Bowel problems	Kidney/bladder problems	
Neck pain	Midback pain	Lower back pain	Shoulder pain	Elbow pain
Wrist pain	Arm pain	Leg pain	Hip pain	Knee pain / Ankle pain
Extreme fatigue	Loss of memory	Attention problems (ADD/ADHD)	Headaches/Migraines	
Cancer	Diabetes	Hypoglycemia	Hepatitis	
Cold hands/feet	Multiple Sclerosis	Thyroid Problems	Muscular Dystrophy	
Asthma	Allergies	Epilepsy	Pacemaker	
Heart problems	Chest pain	High Cholesterol	High Blood Pressure	
Other				

Previous care

Have you ever had chiropractic care in the past? ☐ Yes ☐ No	
If yes, when?	Doctor seen
Reason for care?	Date of last treatment
Have you ever had x-rays taken? ☐ Yes ☐ No	
Please list current medications	
Please list herbal or vitamin supplementation	

How often do you exercise?	What type of exercise?
Do you smoke? ☐ Yes ☐ No If yes, how many per day?	