TAYLOR WELLNESS & CHIROPRACTIC CLINICS

ADULT NEW PATIENT QUESTIONNAIRE

NAME:_____ DATE:_____
ADDRESS:_____ CITY:_____ POSTAL CODE:_____
HOME PHONE:_____ CELL PHONE:_____ BUSINESS PHONE:_____
EMAIL ADDRESS:_____
DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS:_____ #CHILDREN:_____
EMPLOYER:_____ OCCUPATION:_____

Who referred you to this clinic?:_____
Do you have any extended health care insurance? YES ☐ NO ☐
Chiropractic, Massage Therapy, or Orthotic Coverage? YES ☐ NO ☐
Is this a WSIB (Workman's Comp) case? YES ☐ NO ☐

Family Doctor:_____ Phone:_____
Date of last spinal x-rays:_____ Where?:_____
Have you ever consulted a chiropractor?:_____ If yes, Dr._____ When?:_____
What is your chief complaint?:_____
_____
When did this start?:_____
Have you had any car accidents, falls or fractures? Please list all & approximatel dates for each:_____
_____
Are you under any stress?:_____ List drugs you take:_____
_____

Have you had any of the following surgery/conditions?

SPINAL SURGERY ☐	GALL BLADDER ☐	TONSILS ☐	HYSTERECTOMY ☐
HEART SURGERY ☐	CESAREAN ☐	DIABETES ☐	STROKE ☐
CANCER ☐	HEART ATTACK ☐	OSTEOPOROSIS ☐	OTHER ☐

Please check any problems you presently have or have had in the past year, (Many symptoms can be a result of nerve/tension to those areas of the body):

CERVICAL SPINE (NECK)
- ☐ NECK PAIN
- ☐ HEADACHES
- ☐ SHOULDER PAIN (BURSITIS)
- ☐ TENNIS ELBOW/WRIST PAIN
- ☐ PAIN RADIATING TO THE ARM/HAND
- ☐ JAW PROBLEMS
- ☐ DIZZINESS
- ☐ NERVOUSNESS
- ☐ RECURRING EARACHES/INFECTIONS
- ☐ RECURRING SINUS CONGESTION
- ☐ VISUAL DISTURBANCES
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ DIFFICULTY SLEEPING
- ☐ NAUSEA/VOMITING
- ☐ FATIGUE

LUMBAR SPINE (LOWER BACK)
- ☐ LOWER BACK PAIN
- ☐ SACROILIAC PAIN
- ☐ PAIN RADIATING INTO THE LEG
- ☐ NUMBNESS INTO THE FOOT
- ☐ KNEE PAIN/ANKLE/FOOT PAIN
- ☐ GROIN AND/OR TESTICULAR PAIN
- ☐ CONSTIPATION/DIARRHEA
- ☐ HEMORRHOIDS
- ☐ BLADDER CONTROL PROBLEMS
- ☐ FREQUENT URINATION AT NIGHT
- ☐ IMPOTENCE
- ☐ IRREGULAR MENSTRUAL CYCLE
- ☐ MENSTRUAL CRAMPS/BACK PAIN
- ☐ DIFFICULTY GETTING PREGNANT

THORACIC SPINE (MIDDLE BACK)
- ☐ PAIN BETWEEN SHOULDER BLADES
- ☐ PAIN INTO THE RIBS
- ☐ PAIN RADIATING TO CHEST
- ☐ SHINGLES
- ☐ ASTHMA
- ☐ HEART PALPITATIONS
- ☐ RECURRING INDEGESTION
- ☐ GAS/BELCHING
- ☐ NAUSEA/VOMITING

GENERAL SYMPTOMS
- ☐ ALLERGIES
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ SLURRED SPEECH
- ☐ LOSS OF SMELL/TASTE
- ☐ NUMBNESS OF FACE/LIPS/TONGUE

Are you pregnant? YES ☐ NO ☐ NOT APPLICABLE ☐
Do you smoke? If yes, how much?:_____
Do you exercise? If yes, how much?:_____

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