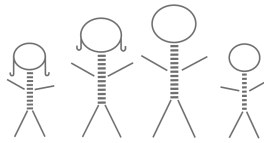


CLEARBROOK
CHIROPRACTIC AND MASSAGE CLINIC

Confidential Patient Questionnaire

PERSONAL INFO

First Name: ______________________ Last Name: ______________________ Middle Name: ______________

Date of Birth (D/M/Y): _______/_______/_______/ Age: _____________ Male ☐ / Female ☐

Home Address: ____ City: ___________________ Province: ____

Postal Code: ________________________ Personal Health Number (PHN): ___________________________

Telephone/Cell: ______________________________ E-mail: ____

I prefer phone reminders ☐ / I prefer e-mail reminders ☐ / No preference ☐

Have you seen a Chiropractor before? Yes ☐ / No ☐

How long ago: ____________________ Name: _____________________________ City: ______________

Was it a good experience? Yes ☐ / No ☐

Do you have a Medical Doctor? Yes ☐ / No ☐

Name: ________________________ Clinic Name: ____________________________City: ______________

How did you hear about our office?

Friend ☐ / Family ☐ / Medical Doctor ☐ / Other Health Professional ☐ / Yellow Pages ☐ / Website ☐

If referred, who may we thank for referring you to our clinic? _____________________________________

PRESENTING COMPLAINT

In your own words describe your **main complaint** or reason for your visit?

When did it start? If possible list the exact date, or approximately how many days ago it started:

____

If possible, **describe in detail how** you injured yourself?

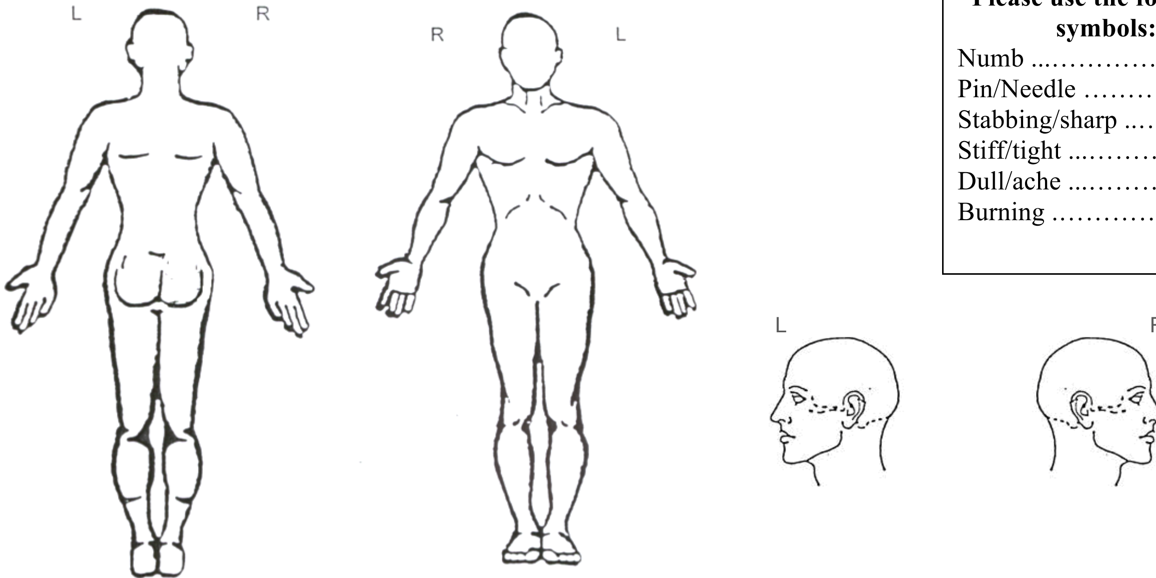
Occupation (*If you're a student, indicate this*): ____

Employer (*or school name*):____ Full or part time? ________

Have you missed work or school because of your injury? Yes ☐ / No ☐

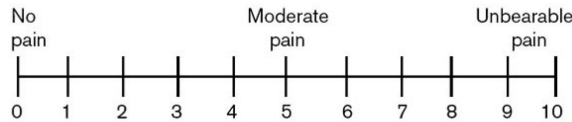
How many missed days? ____

Mark the diagram below to represent **where you feel your symptoms now**:



Please use the following symbols:
Numb ..……………. = = =
Pin/Needle ………… o o o
Stabbing/sharp ..…… ~ ~ ~
Stiff/tight ...………… 2 2 2
Dull/ache ...………… * * *
Burning …………… x x x

Rate your symptoms now:



My complaint is progressively: Getting better ☐ / Staying the same ☐ / Getting worse ☐

This complaint is: Constant ☐ / Comes and goes ☐

The symptoms are worse in the: Morning ☐ / Daytime ☐ / Evening ☐

Which of the following makes your symptoms worse:

Lifting ☐/ Bending forward ☐ / Bending backward ☐ / Bending to the side ☐ / Twisting ☐
Sneezing ☐/ Straining ☐ / Coughing ☐ / Walking ☐ / Sitting ☐ / Sleeping ☐
Working ☐ / Driving ☐ / Reading ☐ / Concentrating ☐ / Dressing ☐/ Homecare ☐
Playing sports ☐ / Social Activities ☐ / Other: ______________________________________

Which of the following make your symptoms better:

Ice ☐/ Heat ☐ / Stretching ☐ / Showering or bathing ☐ / Exercising ☐/ Rest ☐
Taking medications ☐ / Bending a particular way ☐ / Other: __________________________

MEDICAL HISTORY

When was your last physical or visit to your medical doctor? ____

Have you ever had advanced imaging? X-ray ☐ / CT ☐ / MRI ☐ / No Imaging ☐ / Other: __________________

Did they find anything important? ____

What **medications** are you currently taking: ____

Check any **significant medical conditions** you have:

Migraines ☐
Arthritis ☐
Osteoporosis ☐
Fracture in the last year ☐
Cancer ☐
Infection ☐

Anemia/Blood Disorder ☐
Heart Disease / Stroke ☐
Spinal Fusions ☐
Sciatica/Disc Herniation ☐
Diabetes ☐
Double Jointed ☐

Psychological Disorder ☐
Depression ☐
Seizures ☐
Gastrointestinal disorder ☐
HIV or Hepatitis ☐
Other: ________________

Do you smoke? Yes ☐ / No ☐ How many cigarettes or packs per day: _________________

Do you exercise outside of work (ie. involved in sports, go to a gym, yoga, walking program)? Yes ☐ / No ☐

Have you ever been hospitalized? Yes ☐ / No ☐ *(For example: surgeries, traumas, illness, pregnancy)*
Include **details** and **dates** below:

Have you ever been in a Motor Vehicle Accident? Yes ☐ / No ☐
Include **details** and **dates of accidents** below.

Medical Screening Questions:

Quickly scan the list below and ☑ check any medical symptoms you currently have or have experienced recently.

General Symptoms	Neurological	Cardiovascular	Respiratory	Eye/Ears/Nose/Throat
☐ Good heath lately	☐ I have nerve problems	☐ I have heart problems	☐ I have respiratory problems	☐ I have eye problems
☐ Headache	☐ Recent head injury	☐ High blood pressure	☐ Difficulty breathing	☐ I have ear problems
☐ Vertigo	☐ Sciatica	☐ Past heart surgery	☐ Shortness of breath	☐ I have throat problems
☐ Loss of weight	☐ Tingling in arms	☐ Chest pain/Angina	☐ Chronic or frequent cough	☐ Sensitivity to light
☐ Gain of weight	☐ Tingling in legs	☐ Anemia (low blood #)	☐ Spitting up blood	☐ Sensitivity to sound
☐ Fever	☐ Dizziness	☐ Carotid occlusion	☐ Coughing up mucous	☐ Loss of vision
☐ Fatigue (lack of energy)	☐ Problem swallowing	☐ Varicose veins	☐ Asthma or wheezing	☐ Loss of hearing
☐ Tiredness	☐ Blurred vision	☐ Swelling of feet/ankles	☐ Snore	☐ Earache
☐ Loss of sleep	☐ Double vision	☐ Palpitations in chest	**Gastrointestinal**	☐ Ringing/buzz in ears
☐ Nausea	☐ Eyes twitch	☐ Shortness of breath with walking or lying flat	☐ I have intestinal problems	☐ Loss of taste or smell
☐ Chills	☐ Legs want to give out		☐ Liver/Gallbladder problems	☐ Frequent colds
☐ Excess sweating	☐ Loss of balance	**Genitourinary**	☐ Loss of appetite	☐ Frequent sinus issues
☐ Night sweats	☐ Clumsiness	☐ I have kidney problems	☐ Unusual stool (ie.blood)	☐ Thyroid problems
☐ Night pain	☐ Slurred speech	☐ I have bladder problems	☐ Change in bowel movement	**Women**
☐ Chronic pain	☐ Lost memory	☐ Pain urinating	☐ Painful bowel movement	☐ Lump in breasts
☐ Generalized pain	☐ Loss of consciousness	☐ Can't produce urine	☐ Frequent diarrhea	☐ Period significantly disrupts life or work
☐ Depression	☐ Fainting	☐ Don't make it to toilet	☐ Constipation	☐ Irregular/absent period
☐ Nervousness	☐ Blackouts	☐ Blood in urine	☐ Pain in Abdomen	☐ Excessive flow
☐ Anxiety	☐ Tremors or shaking	☐ Bedwetting	☐ Peptic ulcer	☐ Cramping/backache
☐ Stress	☐ Convulsions	**Skin**	☐ Hurts to eat spicy food	☐ Complex pregnancy
☐ Insomnia	☐ No bowel control	☐ I have skin problems	☐ Hurts to eat fatty foods	☐ Hot flashes
☐ Hard concentrating	☐ No bladder control	☐ Unusual mole or lumps	☐ Excessive belching or gas	☐ Menopausal
☐ Irritability	☐ Paralysis	☐ Rashes/itching	☐ Eating disorder	**Men**
☐ Difficulty walking		☐ Bruise easy	☐ I have Celiac or IBD	☐ Prostate trouble
☐ Weakness (lack normal strength)		☐ Allergy to:	☐ Jaundice or changes in skin color	☐ Pain, swelling, or new lumps on male anatomy

Check or list any important medical conditions found in your family:

Breast Cancer ☐ / Prostate Cancer ☐ / Diabetes ☐ / Stroke ☐ / Heart disease ☐ / Osteoporosis ☐ / Arthritis ☐

Other:____