



Halton Chiropractic Clinic  
 250 Wycroft Road, Suite 5  
 Oakville, ON L6K 3T7  
 Tel: 905.844.9117  
 Fax: 905.844.9118  
 www.haltonchiropractic.ca  
**Dr. Larry Laughlin**

## CHIROPRACTIC NEW PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_  
(Street) (City)  
 \_\_\_\_\_  
(Province) (Postal Code)

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_  
(Day / Month / Year)

Birth Place: \_\_\_\_\_ Weight: \_\_\_\_\_

Gender: M or F (Please Circle) # of children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Name) (Relationship) (Phone)

Family physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**EXTENDED HEALTH INSURANCE:** Yes No (Please Circle)

**Is your injury work related?** Yes No  
*(If YES, please request our WSIB Forms.)*

**Has your employer filled out a WSIB injury report?** Yes No  
 WSIB claim number \_\_\_\_\_

**Is your injury a direct result of a Motor Vehicle Accident?** Yes No  
*(If YES, please request our MVA Forms.)*

# HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_

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*PLEASE CIRCLE ANY CONDITIONS WHICH ARE PRESENTLY CAUSING YOU A PROBLEM.*

## GENERAL SYMPTOMS

Headache  
Fever  
Chills  
Sweats  
Fainting  
Dizziness  
Convulsions  
Loss of sleep  
Fatigue  
Nervousness  
Loss of weight  
Numbness or pain in  
Arms, hands, legs  
Allergy  
Wheezing  
Neuralgia

## E.E.N.T.

Failing vision  
Near sightedness  
Far sightedness  
Crossed eyes  
Eye pain  
Deafness  
Earache  
Ear discharge  
Nose bleeds  
Nasal obstruction  
Sore throat  
Hoarseness  
Hay fever  
Asthma  
Dental decay  
Gum trouble  
Frequent colds  
Enlarged thyroid  
Tonsillitis  
Sinus infection  
Nasal drainage  
Enlarged glands

## SKIN

Skin eruptions  
Itching  
Bruises easily  
Dryness  
Boils  
Varicose veins  
Sensitive skin  
Hives or allergy

## RESPIRATORY

Chronic cough  
Spitting up phlegm  
Spitting up blood  
Chest pain  
Difficult breathing

## CARDIOVASCULAR

Rapid beating heart  
Slow beating heart  
High blood pressure  
Low blood pressure  
Pain over heart  
Previous heart stroke  
Hardening of arteries  
Swelling of ankles  
Poor circulation  
Paralytic stroke

## MUSCLE & JOINT

Stiff neck  
Back ache  
Neck pain  
Swollen joints  
Painful tail bone  
Foot trouble  
Pain in shoulders  
Hernia  
Spinal curvature  
Faulty posture  
Arthritis

## GENITOURINARY

Frequent urination  
Painful urination  
Blood in urine  
Pus in urine  
Kidney infection  
Kidney stones  
Bed wetting  
Inability to control urine  
Prostate trouble

## GASTROINTESTINAL

Poor appetite  
Difficult digestion  
Excessive hunger  
Belching or gas  
Nausea  
Vomiting  
Vomiting of blood  
Pain over stomach  
Constipation  
Colon trouble  
Hemorrhoids (piles)  
Intestinal parasites  
Liver trouble  
Gall bladder trouble  
Jaundice  
Colitis

## FOR WOMEN ONLY

Painful menstruation  
Excessive flow  
Hot flashes  
Irregular cycle  
Cramps or backache  
Previous miscarriage  
Vaginal discharge  
Congested breast  
Lumps in breast  
Menopausal symptoms

*HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE CIRCLE.*

Appendicitis  
Scarlet fever  
Diphtheria  
Typhoid fever  
Pneumonia  
Rheumatic fever  
Polio  
Malaria  
Tuberculosis  
Influenza

Anemia  
Measles  
Mumps  
Small Pox  
Chicken Pox  
Diabetes  
Cancer  
Heart disease  
Goiter

Pleurisy  
Alcoholism  
Venereal infection  
Epilepsy  
Mental disorder  
Eczema  
Gout  
Arthritis  
Whooping cough

*HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE CIRCLE.*

Nervous systems disorders  
Heart disease  
Other form of arthritis

Diabetes  
Tuberculosis  
Allergies

Hypertension Cancer  
Rheumatoid arthritis  
Gout

# HEALTH QUESTIONNAIRE

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Patient Name: \_\_\_\_\_

**PLEASE CIRCLE YES or NO TO THE FOLLOWING QUESTIONS.**

Have you ever been knocked unconscious?.....YES NO  
Are you presently under treatment for this problem?..... YES NO  
Are you presently taking any medications?..... YES NO  
Have you ever been to a chiropractor before? .....YES NO  
Accidents, falls, fractures or dislocations (Please describe):  
  
DO YOU WEAR:      Hearing aid..... YES NO  
                          Eye glasses or contact lenses..... YES NO  
                          Medic alert bracelet..... YES NO  
                          Orthopedic (or other appliance)..... YES NO

**STATE THE APPROXIMATE DATES OF THE FOLLOWING:**

Previous visit to a physician \_\_\_\_\_  
Last physical examination \_\_\_\_\_  
Last eye examination \_\_\_\_\_  
X-rays taken this year \_\_\_\_\_  
.....for what reason \_\_\_\_\_

Describe any regular exercise that you engage in, including number of times per week:

\_\_\_\_\_  
\_\_\_\_\_

How many cigarettes do you smoke on a daily basis, if any? \_\_\_\_\_

## FEMALES ONLY

*Please answer the following questions:*

State the date of the first day of flow of your most recent menstruation. \_\_\_\_\_

For radiology purposes, do you have any reason to suspect that you may be pregnant currently? \_\_\_\_\_

State the date of your most recent PAP test. \_\_\_\_\_

State the date of your most recent breast examination. \_\_\_\_\_

Are you currently using any type of birth control method? (please circle) **YES**                      **NO**

If yes, please specify: \_\_\_\_\_

## PAIN SCALE

Indicate your current level of pain by placing an X on the line below:  
*If multiple sites are involved please identify with an arrow.*

No pain                      1    2    3    4    5    6    7    8    9    10                      Severe pain