



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

CHIROPRACTIC
NEW PATIENT QUESTIONNAIRE

Name: (Last) (First) Date:

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

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

E-mail Address:

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

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: _____

Halton Chiropractic Clinic
250 Wycroft Road, Suite 5
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905.844.9117
Dr. William Stackhouse

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
Cancer

Diabetes
Tuberculosis
Allergies

Hypertension
Rheumatoid arthritis
Gout

HEALTH QUESTIONNAIRE

Patient Name: _____

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Dr. Ryan Laughlin

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