Halton Chiropractic Clinic
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Dr. Bill Stackhouse

CHIROPRACTIC

NEW PATIENT QUESTIONNAIRE

(Please Print Clearly)

Name: _____Date:_____
(Last) (First)

Address: _____
(Street) (City)

_____
(Province) (Postal Code)

Phone: Home (____) _____Work (____) _____Ext:_____ Cell (____) _____

Email Address: _____

Date of Birth: _____ Age: _____ Height: _____
(Day / Month / Year)

Birth Place: _____ Weight: _____

Gender: M or F or Other (Please Circle) # of children: _____

Emergency Contact: _____ _____ (___)_____
(Name) (Relationship) (Phone)

Family Physician _____ Referred by: _____

Occupation: _____

Employer's Name: _____

(Optional): Instagram: _____ Facebook: _____

Please follow us for news and updates!
@HaltonChiropracticClinic on Instagram AND @Halton Chiropractic on Facebook

EXTENDED HEALTH INSURANCE: Yes No (Please Circle)

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

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

HEALTH QUESTIONNAIRE

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

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
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
Sitting up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Previous heart store
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
Alcoholism
Venereal infection
Mental disorder
Epilepsy
Eczema
Gout
Arthritis
Whooping cough

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

Nervous systems disorder
Heart disease
Other forms of arthritis
Diabetes
Tuberculosis
Allergies
Hypertension Cancer
Rheumatoid arthritis
Gout

HEALTH QUESTIONNAIRE

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 _____
and for what reason _____

Describe any regular exercise that you engage in.

_____

How many cigarettes do you smoke on a daily basis? _____

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 at the present time?_____

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? 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

1 2 3 4 5 6 7 8 9 10

No pain Severe pain