Date _____

Kensington **Chiropractic for Health**

HEALTH QUESTIONNAIRE

Patient Name _____

1. Please describe your symptoms _____

When did your symptoms start? _____

How did your symptoms begin? _____

What makes your symptoms *Better?* _____ *Worse?*_____

2. How often do you experience your symptoms?

Constantly (76-100% of the day)

Frequently (51-75% of the day)

Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

3. What best describes your symptoms?

Sharp Dull Dull ache

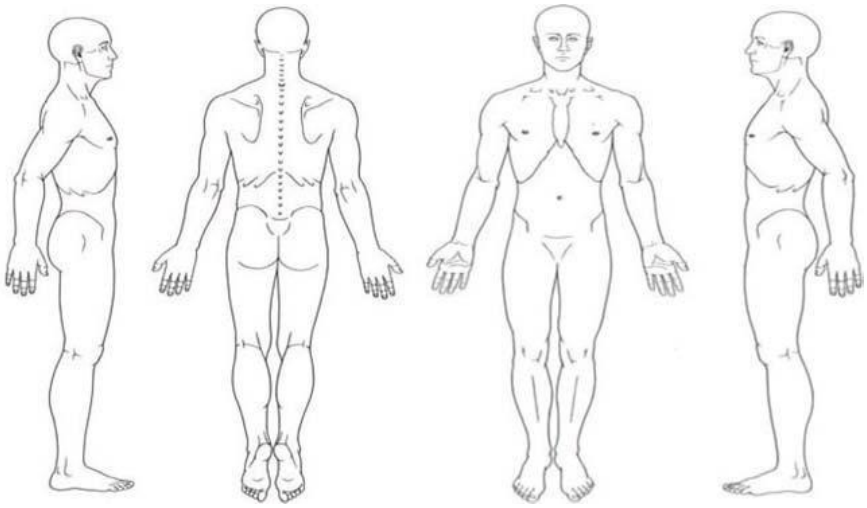
Burning Numb Tingling

4. How are your symptoms changing?

Getting better

Staying the same

Getting worse



Please indicate where you have pain or other symptoms on the diagram.

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 10
None Unbearable

b. How much has the pain interfered with your normal activities? (Including work, house work, caring for family)

Not at all A little bit Moderately Quite a bit Extreme

c. How much has the pain interfered with your social activities? (Sports, exercise, visiting friends and relatives, etc)

Not at all A little bit Moderately Quite a bit Extreme

6. Have you had any previous chiropractic care? _____

Please rate how happy you were with your care 0 1 2 3 4 5 6 7 8 9 10
Very unhappy Very happy

6. Who have you seen for your symptoms? No one Medical doctor Other _____
Chiropractor Physiotherapist

a. *What treatment did you receive and when?* _____

b. What tests have you had for your symptoms and when were they performed?

X-rays MRI CT Other *Date and location:*_____

7. If you have received treatment in the past for the same or a similar symptom, who did you see? This office MD/GP Chiro Physio Other:_____

8. What are you taking or doing for your symptoms? *(Circle)* Heat/Ice Rest Medication_____
Movement Stretch Other _____

9. How would you rate your health right now? 0 1 2 3 4 5 6 7 8 9 10
Very poor Excellent

10. What type of regular exercise do you perform? *(Please list activity/ies)*

None Light Moderate Strenuous _____ ___ times/ week

11. Please list your hobbies and other activities: _____

12. In what position do you sleep? *(Circle any that apply)* Back Front Side

13. How old is your pillow? _____ mattress***?*** _____

HEALTH QUESTIONNAIRE – P2

Patient Name: _____

14. What is your height and weight? Height: _____cm Weight: _____ kg

b. What are your weight goals? Gain _____ kg Maintain Lose ____ kg

c. Have you experienced recent unexplained weight loss? Yes No

15. Do you smoke? No Yes _____ ***16. Do you use recreational drugs?*** No Yes_____

17. How frequently do you consume alcohol? _____ standard drinks per day/week/month/year

18. Do any immediate family members have any of the following?(*Circle)*

Rheumatoid arthritis Diabetes Cancer Cardiovascular disease Osteoarthritis

Scoliosis Lupus SLE/Psoriasis Mental health illness/depression Migraines

19. For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you presently (within the last 4 weeks) have a condition, please place a check in the PRESENT column. Please check both columns if both apply.

Past	*Present*	
❍	❍	Neck pain
❍	❍	Upper back pain
❍	❍	Lower back pain
❍	❍	Shoulder pain
❍	❍	Numbness/tingling arms/legs
❍	❍	Elbow/upper arm pain
❍	❍	Wrist pain/lower arm pain
❍	❍	Hand pain
❍	❍	Hip/thigh pain
❍	❍	Knee/lower leg pain
❍	❍	Ankle/foot pain
❍	❍	Wear foot orthotics
❍	❍	Headaches/Migraines
❍	❍	Jaw pain
❍	❍	Joint swelling/stiffness
❍	❍	Arthritis/gout
❍	❍	Rheumatoid arthritis
❍	❍	Systemic lupus
❍	❍	General fatigue
❍	❍	Un-coordination
❍	❍	Visual disturbances
❍	❍	Dizziness

Past	*Present*	
❍	❍	High blood pressure
❍	❍	Heart attack
❍	❍	Chest pains
❍	❍	Stroke
❍	❍	Angina
❍	❍	Loss of appetite
❍	❍	Bladder infection
❍	❍	Kidney disorders (incl. stones)
❍	❍	Loss of bladder or bowel control
❍	❍	Diabetes
❍	❍	Excessive hunger or thirst
❍	❍	Abdominal pain
❍	❍	Ulcers
❍	❍	Hepatitis
❍	❍	Liver/gallbladder disorder
❍	❍	Cancer _____
❍	❍	Tumour _____
❍	❍	Unexplained weight loss
❍	❍	Unexplained weight gain
❍	❍	Recurrent infections
❍	❍	Asthma
❍	❍	Allergies _____
❍	❍	Hayfever
❍	❍	Chronic or acute sinusitis

Past	*Present*	
❍	❍	Seizures
❍	❍	Epilepsy
❍	❍	Drug/alcohol dependence/abuse
❍	❍	Dermatitis/eczema/psoriasis/rash
❍	❍	HIV/AIDS
Women only		
❍	❍	Last menstrual period _____
❍	❍	Contraceptive _____
❍	❍	Irregular menstruation
❍	❍	Uterine fibroids/Ovarian cysts
❍	❍	Pregnancy _____
❍	❍	Breastfeeding
❍	❍	Infertility/IVF
❍	❍	Caesarean section
❍	❍	Menopause/peri menopause
❍	❍	Hormone replacement
Men only		
❍	❍	Prostate problems
❍	❍	Painful urination
❍	❍	Frequent urination
❍	❍	Waking at night to urinate
❍	❍	Erectile dysfunction
❍	❍	Infertility

20. Please list all prescription and over-the-counter medications you are taking, including doses.

_____ _____ _____

21. Please list all supplements, including vitamins, minerals and dietary supplements, including brands and doses.

_____ _____ _____

22. Please list all accidents, injuries, motor vehicle collisions, fractures/dislocations and concussions. Please include dates.

_____ _____ _____

23. Please list all surgical procedures you have undergone, as well as hospitalizations. Please include reason and date.

_____ _____ _____

Thank you for taking the time to complete this form.

_____ _____ _____

Name (Printed) *Patient (or Guardian) Signature* *Date*