# NEW PATIENT QUESTIONAIRE

Present Complaint:

_____

_____

Pain or Problem started on:

_____

Did it occur at: ☐Home ☐Car Accident ☐Sport ☐Work ☐Other

_____

How did it occur: _____

_____

What activities aggravate your condition/pain?

_____

What activities relieve your condition/pain?

_____

Is the condition/pain worse at certain times of the day?

_____

Is this condition/pain interfering with: ☐ Work ☐ Sleep ☐ Daily Activities

_____

Other treatment for this problem: ☐ GP ☐ Chiropractic ☐ Physiotherapist ☐ Specialist ☐ Other

_____

Treatment received:

_____

_____

Have you had X-rays/scans: ☐ No ☐ Yes What areas were X-rayed/Scaned?

_____

Medications you now take:

_____

_____

Previous surgical operations and year:

_____

_____

Previous major accidents (eg motor vehicle) and year:

_____

_____

**General Health:** Do you suffer from any of the following even if they do not seem to relate to your current condition?

| | | |
|---|---|---|
| ☐ Neck Pain/Stiffness | ☐ Numbness in Fingers | ☐ Fever |
| ☐Shoulder Pain/Stiffness | ☐ Muscle Cramps | ☐ Constipation/Diarrhea |
| ☐ Lower Back Pain/Stiffness | ☐ Headaches | ☐ Blood Pressure (high/low) |
| ☐ Hip/Groin Pain | ☐ Dizziness | ☐ Epilepsy |
| ☐ Leg Pain | ☐ Nausea/Vomiting | ☐ Diabetes |
| ☐Pins & Needles in Legs | ☐ Chest Pain | ☐ Asthma |
| ☐Pins & Needles in Arms | ☐ Shortness of Breath | ☐ Persistent Cough |
| ☐ Numbness in Toes | ☐ Weight Loss | ☐ Cancer |

Other significant conditions: _____

☐ Yes ☐ No If female are you pregnant?

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Do you drink coffee?

☐ Yes ☐ No Do you exercise regularly?

☐ Yes ☐ No Do you wear orthotics?

☐ Yes ☐ No Had recent dental work?

☐ Yes ☐ No Do you sleep well?

Sleeping posture: ☐ Side ☐ Back ☐Stomach ☐ Combination