HEALTH QUESTIONNAIRE

NAME:_____

ADDRESS:_____

PHONE (w)_____(h)_____

DATE OF BIRTH _____/_____/_____

Date_____

1. **Which of the following symptoms have you had in the last 6 Months?**

- ☐ Low back pain
- ☐ Neck pain
- ☐ Hip pain
- ☐ Knee/ankle pain
- ☐ Wrist/ arm pain
- ☐ Muscle Tension/aches
- ☐ Shoulder pain
- ☐ other _____
- ☐ Headaches
- ☐ Leg Pain
- ☐ Dizziness
- ☐ Arthritis/joint pain
- ☐ Nervousness
- ☐ Fatigue
- ☐ Stress
- ☐ Numbness/Tingling
- ☐ Ringing in ears
- ☐ Allergies
- ☐ Asthma
- ☐ Digestive trouble
- ☐ Depression/ mood swings
- ☐ Trouble sleeping

a) Which of the above concerns you most? _____

b) How long have you had it? _____

2. **How does it affect your life?**

- ☐ I lose patience with others
- ☐ I feel exhausted at the end of day
- ☐ I wake up feeling tired
- ☐ I feel moody
- ☐ I get irritable
- ☐ I need to restrict my daily activities
- ☐ I feel I can't exercise
- ☐ I have difficulty making decisions
- ☐ I am less productive
- ☐ My sleep is affected

3. **What have you tried to help you manage your symptoms?**

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Acupuncture
- ☐ Counseling
- ☐ Chiropractic
- ☐ Drugs
- ☐ Naturopathy

Results:_____

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS THERE ARE NATURAL & EFFECTIVE TREATMENT OPTIONS AVAILABLE TO YOU.

☐ Yes, I would like to come to the Doctor's office for a complementary consultation. This will allow me to find out if I can be helped by Chiropractic or Massage Therapy.

☐ Yes, I would like to receive more information about chiropractic

☐ Yes, I would like to receive more information about complimentary Health Talk at my workplace or organization

Black's Family Chiropractic 10 Headdon Gate #5 Richmond Hill, ON L4C 7B6 Tel:(905) 508-4422