Patient Introduction

Date:_____ File #:_____

WELCOME to the chiropractic office of **Dr. Shauna Sommer, D.C.**

Please complete this questionnaire **front and back.** Please print your answers.
They will help us determine if chiropractic can help you.

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

_____ Marital Status:_____
(City) (Province) (Postal Code)

Date of Birth:_____ Age:_____ Ages of Children:_____
(Day) (Month) (Year)

E-Mail:_____ May we contact you about upcoming events and information about our clinic via email? YES or NO

What is your main complaint/ symptoms ? _____

_____

How long have you had this condition?_____ Have you had this condition before?_____

Describe:_____ When ?_____

Does this condition interfere with your: work____ sleep____ daily routine____ other (please explain)_____

When it's at its worst, how does it feel?_____ Rate **pain** level 0-10 (10 is high)____Rate **stress** level____

What makes it feel better?_____ What makes it feel worse?_____

What do you think is the cause of your problem?_____

_____

Other complaints?_____

Do you exercise/ play sports?_____ Frequency:_____

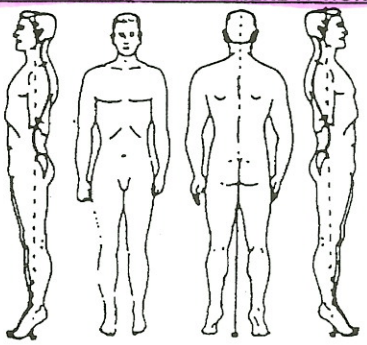
Type of bed (reg, hard/soft, waterbed, etc): _____ Sleeping position:

_____ Any car accidents?____ When ?_____

Are there any family hereditary disorders? If yes, please explain:_____

_____

PLEASE MARK AN "X" WHERE IT HURTS



Do you have any allergies? If yes please list:_____

Occupation/Place of employment_____ Any lifting?____ How many lbs?_____

Have you ever had previous chiropractic care?_____ If yes, when?_____ Same problem?_____

Chiropractor's name:_____ City?_____ Did chiropractic help you?_____

M.D.'s name:_____ Phone number:_____ Last physical:_____

Prescriptions (list):_____ Surgeries: _____

How did you hear about our office? Please circle one:

Facebook Website Mailer Friend/Family (please name)_____ Other:_____

Name of spouse:_____ Occupation:_____

_____

Please turn this form over and complete the other side and sign the bottom