



**Novi Chiropractic Clinic**  
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## New Patient Questionnaire

Print Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status (please circle) M W D S Number of Children \_\_\_\_\_

**REFERRAL:**

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know where you heard about our clinic, or who referred you. \_\_\_\_\_

Main reason for seeking care \_\_\_\_\_

**YOUR BIRTH RECORD:**

Type of birth (vaginal, c-section, forceps, vacuum, or induced) \_\_\_\_\_

List any complications during your mother's pregnancy or during your birth \_\_\_\_\_

List any complications after your birth \_\_\_\_\_

**PATIENT HISTORY:**

Accidents/Injuries you have experienced (ex. Bicycle, car, motorcycle, sports, slips/falls) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were you ever knocked unconscious? \_\_\_\_\_

**SURGERY:**

What surgeries have you had? (include dates) \_\_\_\_\_

\_\_\_\_\_

**MEDICATION:**

What medications (prescription or over-the-counter) are you taking? \_\_\_\_\_

\_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

**\*\*FOR MINORS (Under 18 years of age):**

I am the legal guardian of \_\_\_\_\_, and hereby authorize chiropractic care as is deemed necessary at Novi Chiropractic Clinic.

Relationship \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*FOR WOMEN ONLY:** Is there any possibility that you could be pregnant? (Please circle) YES NO

Patient Name \_\_\_\_\_

**PLEASE FILL IN BELOW**

If you suffer from the following, please check.

| Condition, Symptom, or problem | Constantly or Frequently | Sometimes or Occasionally |
|--------------------------------|--------------------------|---------------------------|
| Headaches                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| Migranes                       | <input type="checkbox"/> | <input type="checkbox"/>  |
| Neck Pain                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| Shoulder Pain                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Arm/Hand Pain                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Mid Back Pain                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Low Back Pain                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Hip Pain                       | <input type="checkbox"/> | <input type="checkbox"/>  |
| Leg/Foot Pain                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Disc Problems                  | <input type="checkbox"/> | <input type="checkbox"/>  |
| Arthritis                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| Other joint pain               | <input type="checkbox"/> | <input type="checkbox"/>  |
| Numbness                       | <input type="checkbox"/> | <input type="checkbox"/>  |
| Joint Swelling                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Dizziness                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| Nausea                         | <input type="checkbox"/> | <input type="checkbox"/>  |
| Weakness                       | <input type="checkbox"/> | <input type="checkbox"/>  |
| Fatigue                        | <input type="checkbox"/> | <input type="checkbox"/>  |
| Nervousness                    | <input type="checkbox"/> | <input type="checkbox"/>  |
| Insomnia                       | <input type="checkbox"/> | <input type="checkbox"/>  |

| Condition, Symptom, or problem | Constantly or Frequently | Sometimes or Occasionally |
|--------------------------------|--------------------------|---------------------------|
| Heart Problems                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Frequent Colds                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Nose Bleeds                    | <input type="checkbox"/> | <input type="checkbox"/>  |
| Hearing Loss                   | <input type="checkbox"/> | <input type="checkbox"/>  |
| Cough                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| Chest Pains                    | <input type="checkbox"/> | <input type="checkbox"/>  |
| Female Problems                | <input type="checkbox"/> | <input type="checkbox"/>  |
| Allergies                      | <input type="checkbox"/> | <input type="checkbox"/>  |
| Asthma                         | <input type="checkbox"/> | <input type="checkbox"/>  |
| Cancer                         | <input type="checkbox"/> | <input type="checkbox"/>  |
| Osteoporosis                   | <input type="checkbox"/> | <input type="checkbox"/>  |
| Diabetes                       | <input type="checkbox"/> | <input type="checkbox"/>  |
| Hypoglycemia                   | <input type="checkbox"/> | <input type="checkbox"/>  |
| Digestive Problems             | <input type="checkbox"/> | <input type="checkbox"/>  |
| Urinary Problems               | <input type="checkbox"/> | <input type="checkbox"/>  |
| Skin Conditions                | <input type="checkbox"/> | <input type="checkbox"/>  |
| Ear Infections                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Sinus Problems                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Blurred Vision                 | <input type="checkbox"/> | <input type="checkbox"/>  |
| Other                          | <input type="checkbox"/> | <input type="checkbox"/>  |

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**Rate your overall health:**

At Novi Chiropractic Clinic we are dedicated toward achieving your goal of total lasting health for each of our patients. To better help you achieve this, we need to understand how you view your overall health. Based on a scale of 10% to 100%, please circle what you feel your current level of health and wellness is.

10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

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**Doctor's Notes:**

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