

Name: \_\_\_\_\_ First name: \_\_\_\_\_

Sex: F  M

Address: \_\_\_\_\_

Date of birth: yy \_\_\_\_ / mm \_\_\_\_ / dd \_\_\_\_

City: \_\_\_\_\_

Married  single  widow  Div.

Postal code: \_\_\_\_\_ phone (home): \_\_\_\_\_

Common Law Spouse \_\_\_\_\_

phone (work): \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you have insurance that covers chiropractic care? Yes  No  Do not know

Who recommended you to our clinic? Friend  Family  Yellow pages  Outside sign  Publicity  other

E-mail: \_\_\_\_\_ His/Her name: \_\_\_\_\_

1. What is the reason for your consultation? Please list your health problems in order of importance: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Since when have you had your main problem?  
 \_\_\_\_\_

3. How did your main problem appear?  
 Gradually  Suddenly   
 Accident/trauma  Do not know

4. Is your problem present...?  
 100% of the time  50% of the time   
 75% of the time  25% of the time   
 Less than 25 % of the time

5. Is your problem getting...?  
 Better  Worst   
 Staying the same

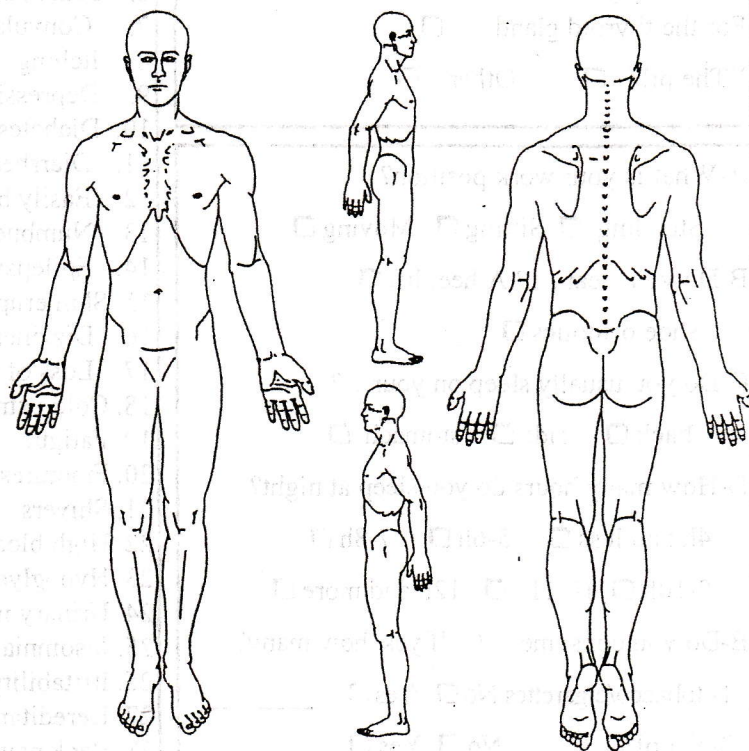
6. Is your problem worse...?  
 morning  day  evening  night

7. Does your problem keep you from...?  
 working  sleeping  your daily routine

8. Have you seen another health professional for your problem? No   
 Chiropractor  Medical  other

9. Have you had your main problem before?  
 no  yes  when: \_\_\_\_\_

Please indicate on the drawings, the exact location of your problems.



Check the box that indicates the severity of your main problem.

No pain            extreme pain  
 0 1 2 3 4 5 6 7 8 9 10

Date of your last examination :  
 less than 6 months 6-18 mo. more than 18 mo never  
 Chiropractic      
 Physical      
 Radiological      
 Blood      
 Urine

**FAMILY HISTORY:**

1-Father: age \_\_\_\_\_ If deceased, cause \_\_\_\_\_

4-Do members of your family have:

2-Mother: age \_\_\_\_\_ If deceased, cause \_\_\_\_\_

Cardiac problems  Cancer

3-Do you have brothers or sisters? yes  No

Diabetes  Arthritis  Other  ?

Are you taking any medication at this time?

No  Relaxants

Anti-inflammatory  Pain killers

Anti-coagulants  Hormones

Muscular relaxants  Insulin

For high blood pressure  Diabetes

For the thyroid gland

``The pill``  Other

Have you had or do you have any of the following problems ?

( Mark the appropriate case)

Yes No

- 1. Allergies
- 2. Anxiety
- 3. Arthritis
- 4. Abdominal gas
- 5. Low blood pressure
- 6. Constipation
- 7. Convulsions
- 8. Itching
- 9. Depression
- 10. Diabetes
- 11. Diarrhea
- 12. Easily bruised
- 13. Numbness
- 14. Epilepsy
- 15. Skin eruptions (redness)
- 16. Dizziness/vertigo
- 17. Loss of consciousness
- 18. Cold extremities
- 19. Fatigue
- 20. Fractures
- 21. Shivers
- 22. High blood pressure
- 23. Hypoglycemia
- 24. Urinary incontinence
- 25. Insomnia
- 26. Irritability
- 27. Hereditary diseases
- 28. Back pain
- 29. Headaches
- 30. Meningitis
- 31. Edema (swelling)
- 32. Operations/surgery

Yes No

- 34.   kidney stones
- 35.   Shaking
- 36.   Foot problems
- 37.   Cardiac problems
- 38.   Blood circulation problems
- 39.   Respiratory problems
- 40.   Eye problems
- 41.   Digestive problems
- 42.   Sexual problems
- 43.   Hearing problems
- 44.   Hormonal problems
- 45.   Psychological problems
- 46.   Kidney problems
- 47.   Varicose vein problems
- 48.   Nose bleeds
- 49.   Blood in the stools
- 50.   Blood in the urine
- 51.   Sinusitis
- 52.   Urinate frequently
- 53.   Urinate at night
- 54.   Prostate problems
- 55.   Cancer

A-What is your work position?

Standing  Sitting  Moving

B-Do you wear ...? A heel lift

Shoe orthotics

C-Do you usually sleep on your...?

back  side  stomach

D-How many hours do you sleep at night?

4h and less  5-6h  7-8h

9-10h  10-11h  12h and more

E-Do you consume...? If yes, how many?

1- tobacco/cigarettes No  Yes  \_\_\_\_\_

2-alcohol No  Yes  \_\_\_\_\_

3-coffee/tea No  Yes  \_\_\_\_\_

4-Do you take vitamins or supplements?

No  Yes  what \_\_\_\_\_

F-Do you exercise? Yes  No

Section reserved for woman

- 56.   No menstruation
- 57.   Abdominal cramps
- 58.   Abundant menstrual flow
- 59.   Painful menstruation
- 60.   Vaginal loss
- 61.   Menopause symptoms
- 62. Are you pregnant?  
Yes  No  May be

PAYMENTS:

X-ray films, examinations and chiropractic treatments are payable at each visit, unless prior financial arrangements have been made. **X-ray films remain the property of the clinic.**

DECLARATION FOR ALL:

I declare that the information given on this form is complete and exact and I consent to receive any necessary examinations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_