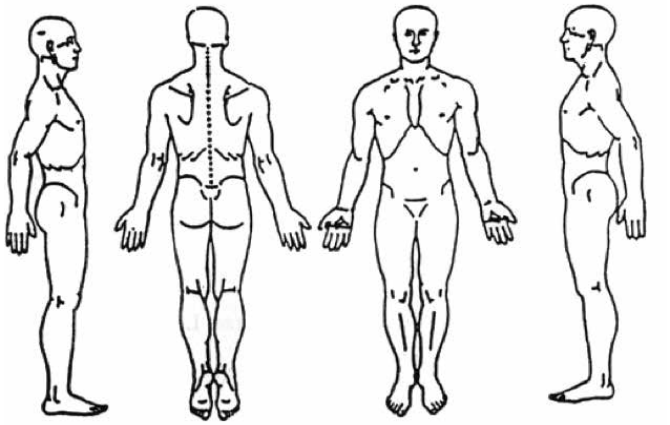
ADMISSION QUESTIONNAIRE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Last name: _____ First name: _____

Date of birth (M/D/Y): ____ / ____ / ____ **Are you consulting**: for preventive reasons ☐ for a particular problem ☐

Please indicate the painful points on the drawing, if applicable.



What is your main reason for consulting?

_____

_____

_____

What other problems do you have, in order of importance?

_____

_____

_____

_____

- How long have you had your main problem? _____
- How intense is your pain? Little pain 1 2 3 4 5 6 7 8 9 10 Extreme pain
- How many days a week does this problem affect you? 1 2 3 4 5 6 7
- How did this problem start? Gradually ☐ Suddenly ☐ Following an accident ☐ I don't know ☐
- Is your problem more intense... when you get up in the morning? ☐ during the day? ☐ in the evening? ☐ at night? ☐

Have you consulted anyone else about this condition? Yes ☐ No ☐

Who? _____ *When?* _____

Have you ever had surgery? Yes ☐ No ☐ **Have you ever been hospitalized?** Yes ☐ No ☐

If so, please specify. _____

_____

_____

Have you been treated for other health problems in the past year? Yes ☐ No ☐

Description _____

_____

History of trauma:

Have you ever: fallen (at work, during childhood, at home, etc.)? Yes ☐ No ☐ _____

been involved in a car/motorcycle/other accident? Yes ☐ No ☐ _____

had a fracture or a dislocation? Yes ☐ No ☐ _____

had a sports injury (e.g. sprain, concussion)? Yes ☐ No ☐ _____

been the victim of another accident? Yes ☐ No ☐ _____

Are you currently taking any medication (prescription or OTC), natural products or nutritional supplements?

Yes ☐ No ☐ If so, which ones? : _____

Anti-inflammatories ☐ Muscle relaxants ☐ Analgesics ☐ Blood pressure medication ☐ Cholesterol medication ☐ Oral contraceptives ☐

Thyroid medication ☐ Diabetes medication ☐ Antidepressants ☐ Anti-anxiety medication ☐ Other: _____

Date of your last: physical examination _____ blood test _____ urine test _____

Are you a: smoker? ☐ ex-smoker? ☐ non-smoker? ☐

Do you suffer from or have you ever suffered from:

General

☐ Night sweats	☐ Fatigue	☐ Weight gain	☐ Unexplained weight loss
☐ Depression	☐ Cancer	☐ Fever	☐ Burnout
☐ Stress	☐ Loss of appetite	☐ Anxiety	☐ Other psychological problems

Neurological

☐ Dizziness/vertigo	☐ Memory loss	☐ Difficulty speaking	☐ Parkinson's disease
☐ Fainting	☐ Headaches	☐ Migraines	☐ Difficulty walking
☐ Stroke	☐ Alzheimer's disease	☐ Weakness	☐ Tremors

Musculoskeletal

☐ Arthritis	☐ Arthrosis	☐ Fracture	☐ Head injury
☐ Neck injury	☐ Back injury	☐ Disc herniation	☐ Scoliosis

Endocrine

☐ Hyperthyroidism	☐ Hypothyroidism	☐ Diabetes	☐ Another hormonal problem

ENT

☐ Vision trouble	☐ Double vision	☐ Loss of hearing	☐ Tinnitus
☐ Ear pain	☐ Glaucoma	☐ Mouth problems	☐ Nosebleeds

Respiratory

☐ Asthma	☐ Cough	☐ Respiratory problems	☐ Chest pain

Other

☐ Anemia	☐ Embolism	☐ Heart attack	☐ Arrhythmia
☐ High blood pressure	☐ Low blood pressure	☐ High cholesterol	☐ Allergies: _____
☐ Heartburn	☐ Ulcers	☐ Difficulty urinating	☐ Incontinence

Men

☐ Prostate problems	☐ Erectile dysfunction	☐ Testicular problems	☐ STBI (STI)

Women

☐ Hot flashes	☐ Absent menstruation	☐ Irregular menstruation	☐ Painful menstruation
☐ Sore breasts	☐ Menopause	☐ STBI (STI)	☐ Infertility

Are you pregnant? Yes ☐ No ☐ If so, when are you expecting? _____

Sleep: Average number of hours of sleep per night _____ Sleep position: back ☐ stomach ☐ side (L or R) ☐

When you wake up, are you: well rested? ☐ tired? ☐ unable to get up? ☐

Activities (sports/recreation): _____

Stress: on a scale of 0 to 10, how would you rate your stress level? 0 1 2 3 4 5 6 7 8 9 10

Diet: Are you concerned about your diet? Yes ☐ No ☐ If so, please specify:

_____

Do you have other health concerns? Yes ☐ No ☐ If so, please specify:

_____

Family history: (e.g. cardiac problems, diabetes, cancer, arthritis, thyroid problems, high cholesterol, stroke)

Mother : _____

Father: _____

Brothers/sisters: _____

Grandparents: _____

I declare that I have filled out this questionnaire to the best of my knowledge.

Patient's signature or signature of person responsible _____ Date: _____