Clinique Chiropratique Familiale de St-Bruno

Last Name: _____ First Name : _____
Date of birth : _____ Age : _____
Address : _____
City : _____Postal Code : _____
Home phone : _____ Mobile phone : _____
Work phone: _____
Email : _____Occupation : _____
*How have you heard of us ?*
☐ Reference (patient's/professional's name) : _____ ☐ OUR WEBSITE
☐ FACEBOOK ☐ INSTAGRAM ☐ YELLOW PAGES Other : _____

*Are you PREGNANT ?* ☐ Yes ☐ No ☐ Maybe.
How many weeks ?: _____ Due date _____

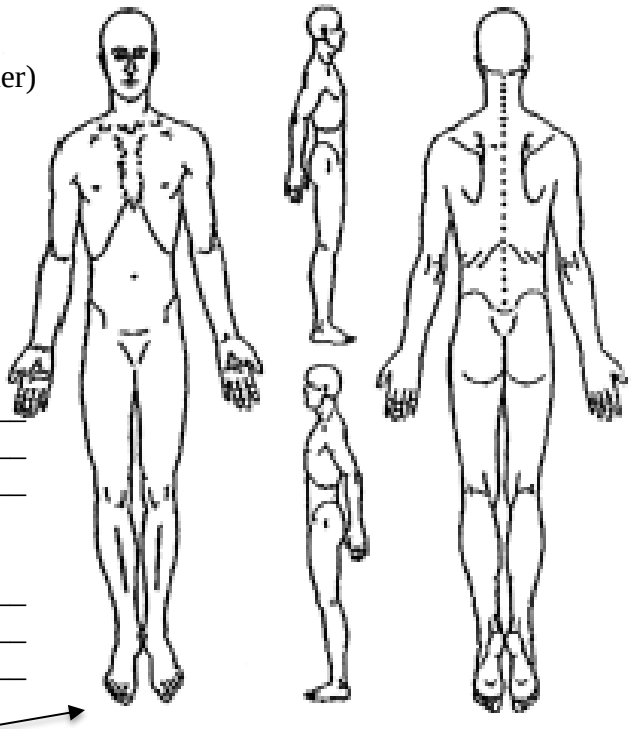
*Do you have children ?* ☐ Yes ☐ No If yes, how many? _____ Ages _____

**Person to contact in case of emergency :** Name: _____ Phone : _____

**REASONS FOR CONSULTING**

☐ Health complaint ☐ Prevention ☐ Pregnancy Follow-up

1. What are your reasons for consulting (by importance order)
   - I. _____
   - II. _____
   - III. _____
2. Since when do you suffer from these ?
   - I. _____
   - II. _____
   - III. _____
3. How did it appear ?
   - I. _____
   - II. _____
   - III. _____
4. How is it progressing ?
   (stable, getting better or getting worse)
   - I. _____
   - II. _____
   - III. _____



5. Indicate the problematic zones on the drawing :
6. How often do you feel your principal symptom (I) ?: ☐ 100% of the time ☐ 75% of the time ☐ 50% of the time ☐ 25 % of the time ☐ less than 25% of the time
7. When is it the worst ? : ☐ In the morning ☐ During the day ☐ In the evening ☐ At night
8. In what position is it the worst ? ☐ Sitting ☐ Standing ☐ Laying down
9. Check the box corresponding to the intensity of your pain :
   No pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Extreme pain
   1 2 3 4 5 6 7 8 9 10
10. Is it the first time you feel this type of pain ? : ☐ yes ☐ no
11. Have you already consult another health professional about this issue ?
    ☐ yes : Which one _____ ☐ no

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**GENERAL HEALTH HISTORY :**

1. Known illnesses :_____
2. Prescription drugs and/or vitamins and/or natural product/homeopathy :
   _____
3. Surgeries (what year ?) : _____
4. Hospitalisations (what year ?) : _____
5. Accidents / falls / fractures (what year?) : _____
6. Do you have allergies ? ☐ Yes :_____ ☐ No
7. What is the name of your doctor and his/her clinic? :_____
8. When was your last medical check-up? : _____
9. Did you get an X-rays exam or an MRI in the last 2 years? ☐ Yes ☐No What body part :
   _____

**HEALTH HABITS :**

1. You spend your day mostly : ☐ Standing ☐ Sitting ☐ Various positions
2. Do you wear orthotic/orthoses ? : ☐ Yes ☐No Prescribed by : _____
3. You sleep mostly on your : ☐Stomach ☐ Back ☐ Left side ☐ Right side
4. Do you smoke ? ☐ Yes (pack/day ____) ☐ No ☐ Ex-smoker (years off : ____)
5. How much do you exercise per week ? ☐ Never ☐ ≤ 1h ☐ 2-4h ☐ ≥ 4h

**Please mark if you suffer from any of these symptoms :**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia | ☐ | Dizziness/Vertigo | ☐ | Itchiness | ☐ | | |
| Anorexia/Bulimia | ☐ | Earaches | ☐ | Irritability | ☐ | | |
| Anxiety/Depression | ☐ | Edema/Swelling | ☐ | Kidney disease | ☐ | | |
| Arthritis/Arthrosis | ☐ | Fatigue | ☐ | Kidney stones | ☐ | Sinusitis | ☐ |
| Asthma | ☐ | Fever | ☐ | Loss of consciousness | ☐ | Tonsillitis/Laryngitis | ☐ |
| Back pain | ☐ | Fracture | ☐ | Meningitis | ☐ | Tinnitus | ☐ |
| Bloating/Gaz | ☐ | Headaches/Migraine | ☐ | Menopause | ☐ | Tremors | ☐ |
| Blood in the stool | ☐ | Hearing problems | ☐ | Menstrual pain | ☐ | Urinary disorder | ☐ |
| Cancer | ☐ | Heart/Vascular conditions | ☐ | Nosebleeds | ☐ | Vaginal discharge | ☐ |
| Cold extremities (such as hands and feet) | ☐ | High/Low blood pressure | ☐ | Numbness | ☐ | Visual disorder | ☐ |
| | | Hormonal problems | ☐ | Prostate dysfunction | ☐ | Weight gain | ☐ |
| Constipation | ☐ | Hypoglycemia | ☐ | Psychological condition | ☐ | Weight loss | ☐ |
| Diabetes | ☐ | Incontinence | ☐ | Respiratory condition | ☐ | | |
| Diarrhea | ☐ | Inherited disease | ☐ | Seizure (epilepsy) | ☐ | | |
| Digestive problems | ☐ | Insomnia/Sleep disorder | ☐ | Sexual disorder | ☐ | | |

**DECLARATION FOR ALL :**

I declare that I have completed this questionnaire to the best of my knowledge. I hereby authorize (Chiropractor's name) _____ to perform the examinations he/she deems necessary. I take responsibility of the costs incurred and the balance not paid by my insurance company. I also consent that my original file is the exclusive property of the Clinique Chiropratique Familiale de St-Bruno.

Signature : _____ Date : _____