OPENING FILE

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 ☐

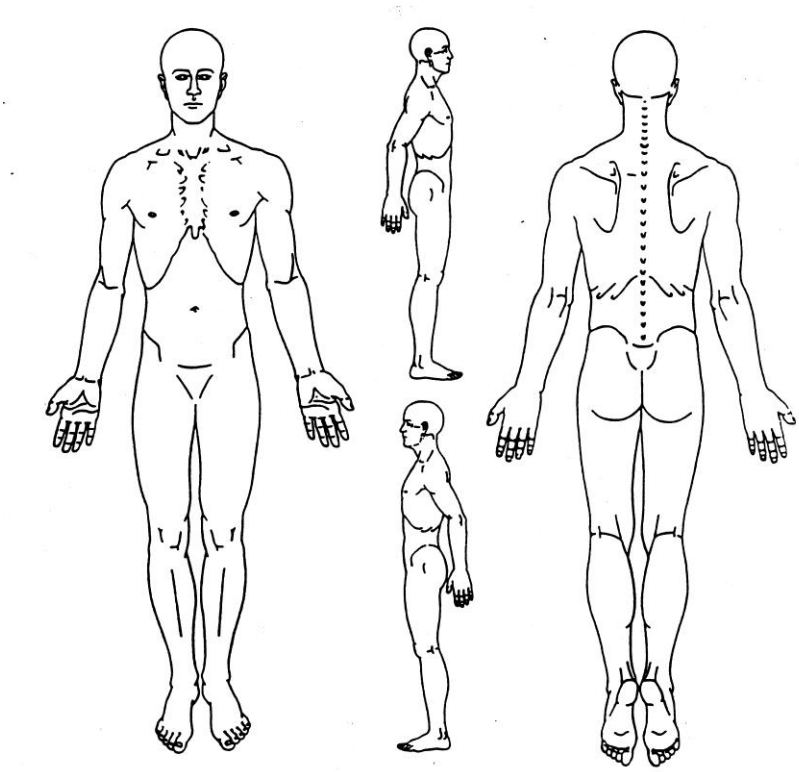
8.Have you seen another health professional for your problem? No ☐

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_____

2-Mother:age____ If deceased, cause_____

3-Do you have brothers or sisters? yes □ No □

4-Do members of your family have:

Cardiac problems □ Cancer □

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 □

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-alcool No □ Yes □ _____

3-coffee/tea No □ Yes □ _____

4-Do you take vitamins or supplements?

No □ Yes□ What_____

F-Do you exercise? Yes □ No □

Have you had or do you have any of the following problems ?
(Mark the appropriate case)

	Yes	No			Yes	No	
1.	□	□	Allergies	34.	□	□	kidney stones
2.	□	□	Anxiety	35.	□	□	Shaking
3.	□	□	Arthritis	36.	□	□	Foot problems
4	□	□	Abdominal gas	37.	□	□	Cardiac problems
5.	□	□	Low blood pressure	38.	□	□	Blood circulation problems
6.	□	□	Constipation	39.	□	□	Respiratory problems
7.	□	□	Convulsions	40.	□	□	Eye problems
8.	□	□	Itching	41.	□	□	Digestive problems
9.	□	□	Depression	42.	□	□	Sexual problems
10	□	□	Diabetes	43.	□	□	Hearing problems
11.	□	□	Diarrhea	44.	□	□	Hormonal problems
12.	□	□	Easily bruised	45.	□	□	Psychological problems
13.	□	□	Numbness	46.	□	□	Kidney problems
14.	□	□	Epilepsy	47.	□	□	Varicose vein problems
15.	□	□	Skin eruptions (redness)	48.	□	□	Nose bleeds
16.	□	□	Dizziness/vertigo	49.	□	□	Blood in the stools
17.	□	□	Loss of consciousness	50.	□	□	Blood in the urine
18.	□	□	Cold extremities	51.	□	□	Sinusitis
19.	□	□	Fatigue	52.	□	□	Urinate frequently
20.	□	□	Fractures	53.	□	□	Urinate at night
21.	□	□	Shivers	54.	□	□	Prostate problems
22.	□	□	High blood pressure	55.	□	□	Cancer
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				

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:_____