

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

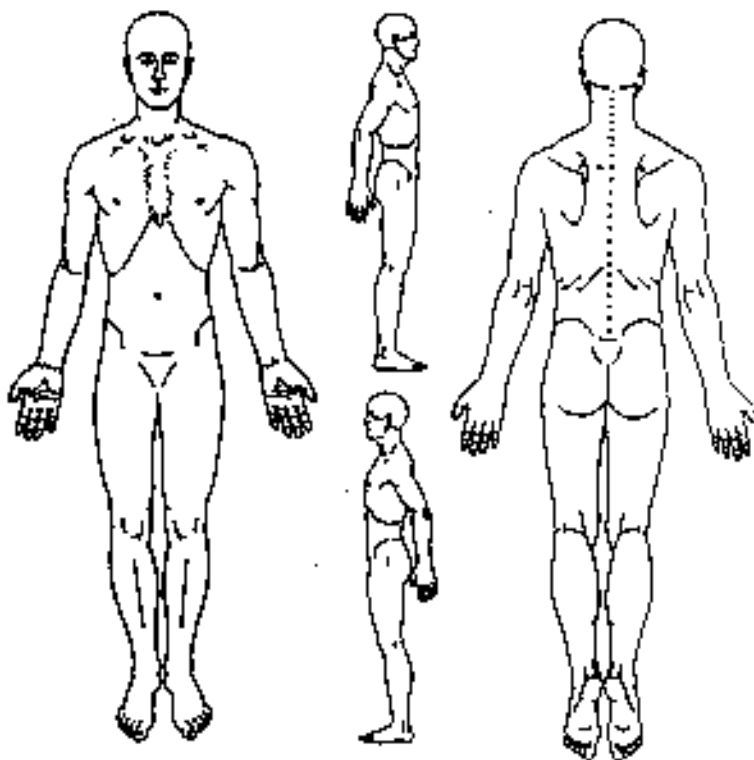
8. Have you seen another health professional for your problem? No

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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-alcohol 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 symbol )

Yes No

1.   Allergies2.   Anxiety3.   Arthritis4.   Abdominal gas5.   Low blood pressure6.   Constipation7.   Convulsions8.   Itching9.   Depression10.   Diabetes11.   Diarrhea12.   Easily bruised13.   Numbness14.   Epilepsy15.   Skin eruptions (redness)16.   Dizziness/vertigo17.   Loss of consciousness18.   Cold extremities19.   Fatigue20.   Fractures21.   Shivers22.   High blood pressure23.   Hypoglycemia24.   Urinary incontinence25.   Insomnia26.   Irritability27.   Hereditary diseases28.   Back pain29.   Headaches30.   Meningitis31.   Edema (swelling)32.   Operations/surgery

Yes No

33.   Loss or gain of weight34.   Kidney stones35.   Shaking36.   Foot problems37.   Cardiac problems38.   Blood circulation problems39.   Respiratory problems40.   Eye problems41.   Digestive problems42.   Sexual problems43.   Hearing problems44.   Hormonal problems45.   Psychological problems46.   Kidney problems47.   Varicose vein problems48.   Nose bleeds49.   Blood in the stools50.   Blood in the urine51.   Sinusitis52.   Urinate frequently53.   Urinate at night54.   Prostate problems55.   Cancer**Section reserved for woman**56.   No menstruation57.   Abdominal cramps58.   Abundant menstrual flow59.   Painful menstruation60.   Vaginal loss61.   Menopause symptoms62. Are you pregnant? Yes  No Maybe **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: \_\_\_\_\_