chiro st-martin

CONSULTATION FORM

Thank you for your trust!

1. INFORMATION

Full name ______

Date of birth *(dd-mm-yy)* ______

Age ______

Address ______

City ______

Postal Code ______

Cell phone ______

Home phone ______

E-mail ______

Confirmation by : ○ e-mail ○ phone

Occupation ______

Do you have children?: ○ No ○ Yes, age ______

Is your treatment covered by insurance?
○ No ○ Yes

Is your case related to : CNESST ? ○ No ○ Yes
SAAQ? ○ No ○ Yes

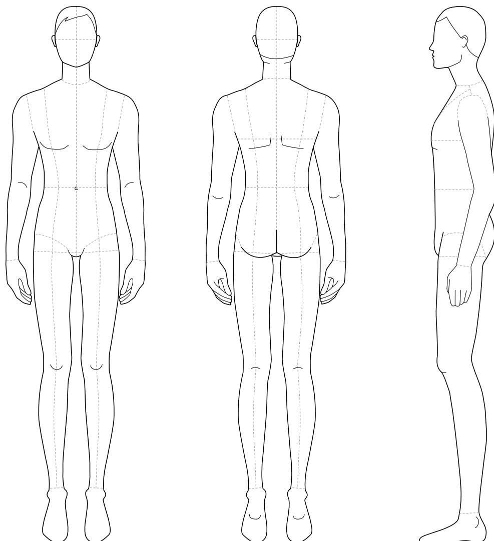
Are you referred by :
○ web site ○ kiosk ○ other : ______
○ patient, name : ______

Your weight ______ and height ______

Are you pregnant? ○ No ○ Yes
Due date ______

2. REASON OF CONSULTATION

Circle the painful spots on the drawing



List your problems in order of severity :

______

______

______

Cause (accident, movement, etc.) :

______

When did it start : ______

How intense is your pain at REST :

0	1	2	3	4	5	6	7	8	9	10

No pain — Extreme pain

How intense is your pain during ACTIVITY :

0	1	2	3	4	5	6	7	8	9	10

No pain — Extreme pain

How many days a week does this problem affect you? ______

If you feel the pain going elsewhere, explain :

______

When is your problem worse?
○ morning ○ evening ○ night ○ constant

What does increase the pain?

______

What does relieve the pain?
○ ice ○ hot ○ medication
○ other : ______

Are there other symptoms?
○ No ○ Yes, which ones : ______

______

Have you consulted anyone else about this condition? ○ No ○ Yes
Who? ______
When? ______

Have you done other tests (e.g. x-ray, scan, IRM, blood test) for your condition?
○ No ○ Yes
Which one? ______
When? ______

Have you ever had pain in this region before?
○ No ○ Yes
When? ______

Have you ever consulted a chiropractor?
○ No ○ Yes, last visit : ______

3. NEUROVERTEBRAL DISORDERS

Problems of the spine come from physical, chemical and emotional stress that have an impact on your health and well-being.

Among these neurovertebral disorders, did you ever have (if yes, when and describe) :

Car accident : ○ No ○ Yes

Accidental fall : ○ No ○ Yes

Sport accident : ○ No ○ Yes

Important trauma : ○ No ○ Yes

4. LIFESTYLE HABITS

Do you practice physical activity? ○ No ○ Yes
Which ones? ____
How many times a week? ____

What is your posture at work?
○ standing ○ sitting ○ repetitive gesture

What is your sleep position?
○ back ○ side left/right ○ stomach

Do you have?
○ firm mattress ○ soft mattress
○ orthopedic pillow

Your diet is :
○ healthy ○ medium ○ bad

Do you consume?
- ○ red meat
- ○ dairy products
- ○ alcohol
- ○ coffee/tea
- ○ energy drinks
- ○ tobacco
- ○ mild drugs

How would you rate your stress level ?

0	1	2	3	4	5	6	7	8	9	10

No stress — Important stress

5. HEALTH PROBLEMS SECTION

Have you ever been hospitalized or had surgery?
○ No ○ Yes, specify :

Indicate your health problems :

Indicate any medication (prescription or OTC), natural products or nutritional supplements :

Indicate your family history health problems :
Mother ____ Father ____
Brother/sister ____

Do you suffer or have you ever suffered from :

GENERAL
- ○ Night sweats
- ○ Fatigue
- ○ Anxiety
- ○ Depression
- ○ Cancer
- ○ Loss of appetite
- ○ Fever
- ○ Weight gain
- ○ Unexplained weight loss
- ○ Loss of genital sensation
- ○ Burnout
- ○ Psychologic problem

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

MUSCULOSKELETAL
- ○ Arthritis
- ○ Arthrosis
- ○ Neck pain
- ○ Back pain
- ○ Numbness in the arm
- ○ Numbness in the legs
- ○ Carpal tunnel syndrome
- ○ Disc herniation
- ○ Scoliosis

ENDOCRINE
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Diabetes
- ○ Hormonal problem

RESPIRATORY
- ○ Asthma
- ○ Cough
- ○ Respiratory problems
- ○ Chest pain

ENT
- ○ Vision trouble
- ○ Otitis
- ○ Double vision
- ○ Glaucoma
- ○ Loss of hearing
- ○ Mouth problems
- ○ Tinnitus
- ○ Nosebleeds

OTHER
- ○ Anemia
- ○ High blood pressure
- ○ Low blood pressue
- ○ Heartburn
- ○ Embolism
- ○ Ulcers
- ○ Heart attack
- ○ High cholesterol
- ○ Difficulty urinating
- ○ Arrythmia
- ○ Allergies : ____
- ○ Incontinence

MEN
- ○ Prostate problems
- ○ Testicular problems
- ○ STBI (STI)

WOMEN
- ○ Hot flashes
- ○ Sore breasts
- ○ Infertility
- ○ STBI (STI)
- ○ Absent menstruation
- ○ Irregular menstruation
- ○ Painful menstruation
- ○ Menopause

I hereby authorize the chiropractor to conduct the examinations necessary. Some patients may feel a slight aggravation of symptoms following the examination and it is important to mention them to the chiropractor.

Patient's signature ____ Date ____