CONSULTATION FORM

Thank you for your trust!

CLINIQUE CHIROPRATIQUE SAINT-MARTIN

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

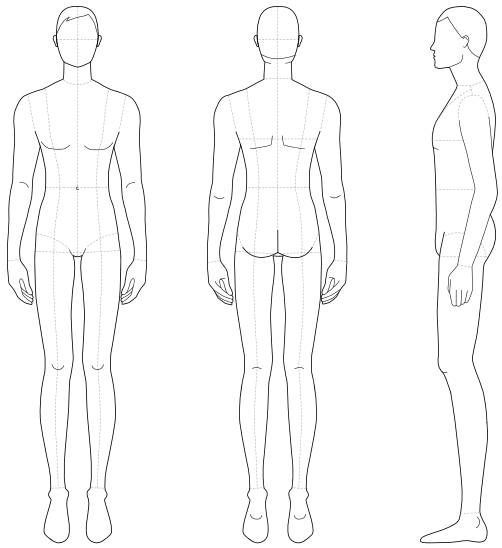
Are you referred by :
○ web site ○ kiosk ○ other : _____
○ patient, name : _____

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 _____