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 □

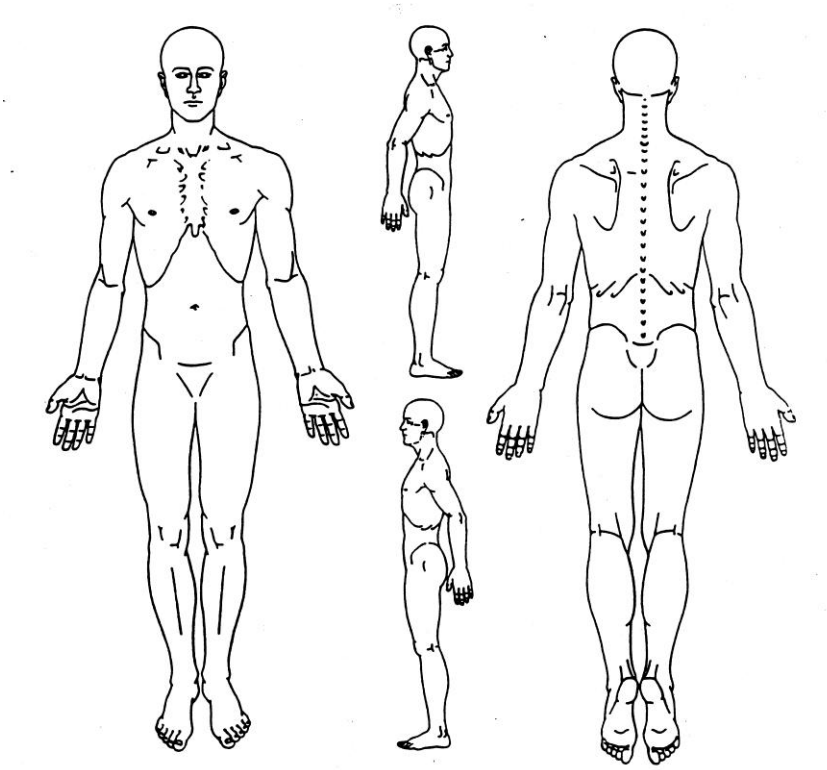
8.Have you seen another health professional for your problem? No □

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	
1.	□	□	Allergies
2.	□	□	Anxiety
3.	□	□	Arthritis
4	□	□	Abdominal gas
5.	□	□	Low blood pressure
6.	□	□	Constipation
7.	□	□	Convulsions
8.	□	□	Itching
9.	□	□	Depression
10	□	□	Diabetes
11.	□	□	Diarrhea
12.	□	□	Easily bruised
13.	□	□	Numbness
14.	□	□	Epilepsy
15.	□	□	Skin eruptions (redness)
16.	□	□	Dizziness/vertigo
17.	□	□	Loss of consciousness
18.	□	□	Cold extremities
19.	□	□	Fatigue
20.	□	□	Fractures
21.	□	□	Shivers
22.	□	□	High blood pressure
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

	Yes	No	
34.	□	□	kidney stones
35.	□	□	Shaking
36.	□	□	Foot problems
37.	□	□	Cardiac problems
38.	□	□	Blood circulation problems
39.	□	□	Respiratory problems
40.	□	□	Eye problems
41.	□	□	Digestive problems
42.	□	□	Sexual problems
43.	□	□	Hearing problems
44.	□	□	Hormonal problems
45.	□	□	Psychological problems
46.	□	□	Kidney problems
47.	□	□	Varicose vein problems
48.	□	□	Nose bleeds
49.	□	□	Blood in the stools
50.	□	□	Blood in the urine
51.	□	□	Sinusitis
52.	□	□	Urinate frequently
53.	□	□	Urinate at night
54.	□	□	Prostate problems
55.	□	□	Cancer

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:_____