

INFORMATION/NEW FILE



Last name: _____ First name: _____ Date of birth: (M/D/Y) _____

Civil status: Married Living common-law Single Divorced Widowed Other Sex: _____

Address: _____ City: _____ Postal code: _____

Home phone: _____ Cell phone: _____

Office phone: _____ E-mail: _____

What is the best way to reach you? Home phone Cell phone Office phone E-mail

Do you authorize the clinic to contact you by e-mail? Yes No

Do you authorize the clinic to leave a message at the specified number to confirm an appointment? Yes No

Occupation: _____ Are you currently on leave from work? Yes No

Do you have any children? Yes No If so, how many? _____

Referred by: Other professional Name: _____ Clinic: _____

Spouse Friend Parent Co-worker Name: _____

Advertisement Website Yellow Pages Facebook Google Other : _____

Name of your family physician: _____
WEIGHT: _____ TALL: _____

Last appointment: _____ Date of last medical examination: _____

Have you ever consulted a chiropractor? Yes No

Who? _____ When? _____

Are you consulting for a problem related to an occupational accident (CNESST)? Yes No

Are you consulting for a problem related to a car accident (SAAQ)? Yes No

Name of representative: _____ File number: _____

Is your treatment covered by a Veterans Program or IVAC? Yes No

Do you agree to have us reply to requests made by your insurer, Veterans Affairs Canada, IVAC, the CNESST or the SAAQ regarding your treatment dates and the amounts paid for those treatments? Yes No

Person to contact in case of emergency:

Last name: _____ First name: _____ Telephone number: _____

Relationship: _____

I hereby authorize the chiropractor to conduct the examinations that he or she deems necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally do not last long, it is important to mention them to the chiropractor at your next appointment.

Patient's signature or signature of person responsible: _____

Date: _____ 2022

ADMISSION QUESTIONNAIRE

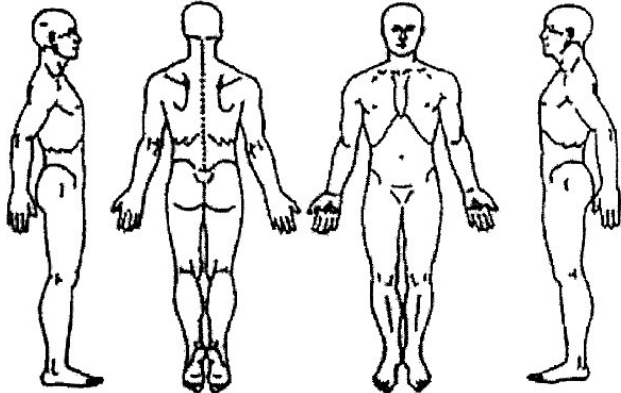


Last name: _____ First name: _____

Date of birth (M/D/Y): ____ / ____ / ____

Are you consulting: for preventive reasons for a particular problem

Please indicate the painful points on the drawing, if applicable.



What is your main reason for consulting?

What other problems do you have, in order of importance?

- How long have you had your main problem? _____
- How intense is your pain? Little pain 1 2 3 4 5 6 7 8 9 10 Extreme pain
- How many days a week does this problem affect you? 1 2 3 4 5 6 7
- How did this problem start? Gradually Suddenly Following an accident I don't know
- Is your problem more intense... when you get up in the morning? during the day? in the evening? at night?

Have you consulted anyone else about this condition? Yes No

Who? _____ When? _____

Have you ever had surgery? Yes No Have you ever been hospitalized? Yes No

If so, please specify. _____

Have you been treated for other health problems in the past year? Yes No

Description _____

History of trauma:

- Have you ever: fallen (at work, during childhood, at home, etc.)? Yes No _____
- been involved in a car/motorcycle/other accident? Yes No _____
- had a fracture or a dislocation? Yes No _____
- had a sports injury (e.g. sprain, concussion)? Yes No _____
- been the victim of another accident? Yes No _____

Are you currently taking any medication (prescription or OTC), natural products or nutritional supplements?

Yes No If so, which ones? : _____

Anti-inflammatories Muscle relaxants Analgesics Blood pressure medication Cholesterol medication Oral contraceptives

Thyroid medication Diabetes medication Antidepressants Anti-anxiety medication Other: _____

Date of your last: physical examination _____ blood test _____ urine test _____

Are you a: smoker? ex-smoker? non-smoker?

Do you suffer from or have you ever suffered from:

General

- | | | | |
|---------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fever | <input type="checkbox"/> Burnout |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other psychological problems |

Neurological

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremors |

Musculoskeletal

- | | | | |
|--------------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Arthrosis | <input type="checkbox"/> Fracture | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Neck injury | <input type="checkbox"/> Back injury | <input type="checkbox"/> Disc herniation | <input type="checkbox"/> Scoliosis |

Endocrine

- | | | | |
|--|---|-----------------------------------|---|
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Another hormonal problem |
|--|---|-----------------------------------|---|

ENT

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Vision trouble | <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mouth problems | <input type="checkbox"/> Nosebleeds |

Respiratory

- | | | | |
|---------------------------------|--------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Chest pain |
|---------------------------------|--------------------------------|---|-------------------------------------|

Other

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Embolism | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Incontinence |

Men

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Testicular problems | <input type="checkbox"/> STBI (STI) |
|--|---|--|-------------------------------------|

Women

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Absent menstruation | <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> Sore breasts | <input type="checkbox"/> Menopause | <input type="checkbox"/> STBI (STI) | <input type="checkbox"/> Infertility |

Are you pregnant? Yes No If so, when are you expecting? _____

Sleep: Average number of hours of sleep per night _____ Sleep position: back stomach side (L or R)

When you wake up, are you: well rested? tired? unable to get up?

Activities (sports/recreation): _____

Stress: on a scale of 0 to 10, how would you rate your stress level? 0 1 2 3 4 5 6 7 8 9 10

Diet: Are you concerned about your diet? Yes No If so, please specify: _____

Do you have other health concerns? Yes No If so, please specify: _____

Family history: (e.g. cardiac problems, diabetes, cancer, arthritis, thyroid problems, high cholesterol, stroke)

Mother: _____

Father: _____

Brothers/sisters: _____

Grandparents: _____

I declare that I have filled out this questionnaire to the best of my knowledge.

Patient's signature or signature of person responsible _____ Date: _____ 2022