CENTRE Kiro spécifik
AJUSTEMENT ORTHOGONAL NUCCA

Date : ____________________

Initial Questionnaire

First name : ________________________ Last name : __________________________

Date of Birth : _____________________ Sex : ☐ Male ☐ Female

Address : _____________________________ City : ____________________ Prov. : ______

Postal Code : _________________ E-mail : __________________________

Phone # (home) : ___________________ Marital status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Phone # (cell) : ___________________

Phone # (work) : _____________________ Number of children : ________

Name of parent (if minor) : _____________________________ Relationship : ______________

How did you hear about us? ☐ Referral/Friend ☐ Internet ☐ Outdoor Sign ☐ Other

Why do you want to consult us?

☐ Pain/Discomfort ☐ Performance ☐ Posture ☐ Prevention ☐ Mobility ☐ Energy
☐ Car Accident ☐ Work Accident ☐ Other : ______________________________________

Please check the appropriate boxes for each type of trauma (even back to childhood)

	Never	1-2 small	3+ small	1-2 major	3+ major
Have you ever been in a car accident?	☐	☐	☐	☐	☐
Did you ever have a work injury?	☐	☐	☐	☐	☐
Did you ever have a sports injury?	☐	☐	☐	☐	☐
Did you ever have a concussion, fall, blow to the head?	☐	☐	☐	☐	☐

Please check the appropriate boxes for symptoms you are PRESENTLY experiencing

Sight
- ☐ Hyperopia (farsighted)
- ☐ Myopia (nearsighted)
- ☐ Presbyopia / Blurred vision

Touch and Sensations
- ☐ Numbness
- ☐ Dizziness
- ☐ No sensation in a limb
- ☐ Tremors

Digestive System
- ☐ Bloating / Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rapid Weight Gain
- ☐ Rapid Weight Loss
- ☐ Heartburn
- ☐ Ulcers

Cardiovascular System
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Fainting
- ☐ Swollen limbs
- ☐ Short breath
- ☐ Varicose veins

Hearing
- ☐ Tinnitus
- ☐ Deafness (1 or 2 ears)

Respiratory System
- ☐ Allergies
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Sinusitis
- ☐ Frequent Coughing

Endocrine System
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid prob. (hyper/hypo)
- ☐ Other hormonal problems

Skin
- ☐ Itching
- ☐ Rash / Redness
- ☐ Cold Hands / Feet
- ☐ Nose bleeding

Musculo-Skeletal System
- ☐ Headaches
- ☐ Migraines
- ☐ Arm pain
- ☐ Leg pain
- ☐ Neck pain
- ☐ Mid-back pain
- ☐ Low-back pain
- ☐ Hand pain
- ☐ Foot pain

Reproductive System (Men)
- ☐ Testicular Pain
- ☐ Erectile Dysfunction
- ☐ Prostate Problems

Reproductive System (Women)
- ☐ Abundant Menses
- ☐ Menstrual Pain
- ☐ Pre-Menopause Symptoms

Urinary System
- ☐ Kidney stones
- ☐ Frequent Urge to Urinate

Wellness
- ☐ Depression
- ☐ Fatigue
- ☐ Insomnia
- ☐ Irritability

Please check any appropriate boxes for diseases or problems you have experienced

Childhood Diseases
- ☐ Pertussis
- ☐ Measles
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Chickenpox

Infectious Diseases
- ☐ Cholera
- ☐ Yellow Fever
- ☐ Typhoid Fever
- ☐ Malaria
- ☐ AIDS - HIV
- ☐ Tuberculosis

Chronic Diseases
- ☐ Rheumatoid Arthritis
- ☐ Emphysema
- ☐ Seizures
- ☐ Fibromyalgia
- ☐ Goiter
- ☐ Hepatitis
- ☐ Chronic Fatigue Syndrome
- ☐ Herniated Disc
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Multiple Sclerosis

Psychological Imbalances
- ☐ Alcoholism
- ☐ Anorexia - Bulimia
- ☐ Drugs Dependence
- ☐ Psychiatric Care
- ☐ Suicide Attempt

Blood Anomalies
- ☐ High Cholesterol
- ☐ Anemia

Cancer
- ☐ Intestinal
- ☐ Ovarian
- ☐ Prostate
- ☐ Skin
- ☐ Lung
- ☐ Breast
- ☐ Uterus

Year of cancer : ___________
Treatments : _______________
____
____

Your Lifestyle

Do you smoke tobacco?	☐ Everyday	☐ Occasionally	☐ Never	
Do you drink alcohol?	☐ Everyday	☐ Occasionally	☐ Never	
Do you exercise or play sports?	☐ Everyday	☐ Occasionally	☐ Never	
Do you drink coffee / caffeinated beverages?	☐ Everyday	☐ Occasionally	☐ Never	
How many hours do you sleep per night?	☐ Less than 6 hrs	☐ 6-8 hrs	☐ 8-10 hrs	☐ 10 hrs +
How many meals do you eat in a day?	☐ 1 sometimes 2	☐ 2 sometimes 3	☐ 3 per day	☐ 3 + / day
How much water do you drink per day?	☐ - than 1 glass	☐ 1-2 glasses	☐ 3 to 6 glasses	☐ 6 + glasses
How would you rate your stress level?	☐ Very stressed	☐ Stressed	☐ Small stress	☐ No stress

Which health professionals have you ever consulted and when was the last time?

	Professional name and City	Never	5 yrs +	1- 5 yrs	Less than 1 y.
Chiropractor	______________	☐	☐	☐	☐
Medical Physician	______________	☐	☐	☐	☐
Medical Specialist	______________	☐	☐	☐	☐
Dentist	______________	☐	☐	☐	☐
Dental Specialist	______________	☐	☐	☐	☐
Physical Therapist	______________	☐	☐	☐	☐
Osteopath	______________	☐	☐	☐	☐
Acupuncturist	______________	☐	☐	☐	☐
Homeopath	______________	☐	☐	☐	☐
Chinese Medicine	______________	☐	☐	☐	☐
Podiatrist	______________	☐	☐	☐	☐
Massage Therapist	______________	☐	☐	☐	☐
Energy Therapist	______________	☐	☐	☐	☐

Informed Consent

The information you are asked to provide your doctor of chiropractic concerning your present and past health are of great importance. These are used to determine any contra-indications which would apply in your case. This information must be complete and accurate to the best of your knowledge.

As with any treatment in the health field, there is a possibility of certain risks associated with treatments ranging from muscle stiffness to extremely rare situations like cerebrovascular complications when adjusting the cervical spine. At all times, your chiropractor will be able to answer any questions you may have regarding chiropractic adjustments. This allows you to make an informed decision about your choice to receive the treatments prescribed by your doctor of chiropractic. Statistics comparing the complications of medical and chiropractic: Surgery for neck pain (Death: 0.69%, Complications: 1.56%), Anti-inflammatory drugs (Deaths: 0.01%, Complications: 0.1%), Chiropractic Adjustments (Death: None in Quebec , Complications: 0.000018%)

I declare that all the information provided above is complete and accurate; I agree to take the exams that the doctor deems necessary and I have read and understood this consent on chiropractic care.

_______________________________ Signature

_______________________________ Date