

Initial Questionnaire

First name : _____ Last name : _____
 Date of Birth : _____ Sex : Male Female
 Address : _____ City : _____ Prov. : _____
 Postal Code : _____ E-mail : _____
 Phone # (home) : _____ Marital Single Married Divorced
 Phone # (cell) : _____ status : Widowed Separated
 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have a work injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have a sports injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have a concussion, fall, blow to the head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check the appropriate boxes for symptoms you are PRESENTLY experiencing

<p><u>Sight</u></p> <p><input type="checkbox"/> Hyperopia (farsighted) <input type="checkbox"/> Myopia (nearsighted) <input type="checkbox"/> Presbyopia / Blurred vision</p> <p><u>Touch and Sensations</u></p> <p><input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness <input type="checkbox"/> No sensation in a limb <input type="checkbox"/> Tremors</p> <p><u>Digestive System</u></p> <p><input type="checkbox"/> Bloating / Gas <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Rapid Weight Gain <input type="checkbox"/> Rapid Weight Loss <input type="checkbox"/> Heartburn <input type="checkbox"/> Ulcers</p>	<p><u>Cardiovascular System</u></p> <p><input type="checkbox"/> Low blood pressure <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting <input type="checkbox"/> Swollen limbs <input type="checkbox"/> Short breath <input type="checkbox"/> Varicose veins</p> <p><u>Hearing</u></p> <p><input type="checkbox"/> Tinnitus <input type="checkbox"/> Deafness (1 or 2 ears)</p> <p><u>Respiratory System</u></p> <p><input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Sinusitis <input type="checkbox"/> Frequent Coughing</p>	<p><u>Endocrine System</u></p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Thyroid prob. (hyper/hypo) <input type="checkbox"/> Other hormonal problems</p> <p><u>Skin</u></p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Rash / Redness <input type="checkbox"/> Cold Hands / Feet <input type="checkbox"/> Nose bleeding</p> <p><u>Musculo-Skeletal System</u></p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Arm pain <input type="checkbox"/> Leg pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Low-back pain <input type="checkbox"/> Hand pain <input type="checkbox"/> Foot pain</p>	<p><u>Reproductive System (Men)</u></p> <p><input type="checkbox"/> Testicular Pain <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Prostate Problems</p> <p><u>Reproductive System (Women)</u></p> <p><input type="checkbox"/> Abundant Menses <input type="checkbox"/> Menstrual Pain <input type="checkbox"/> Pre-Menopause Symptoms</p> <p><u>Urinary System</u></p> <p><input type="checkbox"/> Kidney stones <input type="checkbox"/> Frequent Urge to Urinate</p> <p><u>Wellness</u></p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability</p>
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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? | <input type="checkbox"/> Everyday | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do you drink alcohol? | <input type="checkbox"/> Everyday | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do you exercise or play sports? | <input type="checkbox"/> Everyday | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Do you drink coffee / caffeinated beverages? | <input type="checkbox"/> Everyday | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| How many hours do you sleep per night? | <input type="checkbox"/> Less than 6 hrs | <input type="checkbox"/> 6-8 hrs | <input type="checkbox"/> 8-10 hrs <input type="checkbox"/> 10 hrs + |
| How many meals do you eat in a day? | <input type="checkbox"/> 1 sometimes 2 | <input type="checkbox"/> 2 sometimes 3 | <input type="checkbox"/> 3 per day <input type="checkbox"/> 3 + / day |
| How much water do you drink per day? | <input type="checkbox"/> - than 1 glass | <input type="checkbox"/> 1-2 glasses | <input type="checkbox"/> 3 to 6 glasses <input type="checkbox"/> 6 + glasses |
| How would you rate your stress level? | <input type="checkbox"/> Very stressed | <input type="checkbox"/> Stressed | <input type="checkbox"/> Small stress <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteopath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncturist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeopath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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