INFORMATION/NEW FILE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

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: _____

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 : _____

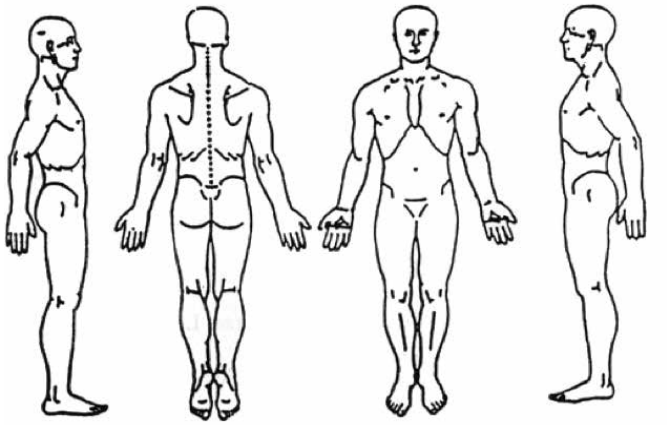
ADMISSION QUESTIONNAIRE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

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

☐ Night sweats	☐ Fatigue	☐ Weight gain	☐ Unexplained weight loss
☐ Depression	☐ Cancer	☐ Fever	☐ Burnout
☐ Stress	☐ Loss of appetite	☐ Anxiety	☐ Other psychological problems

Neurological

☐ Dizziness/vertigo	☐ Memory loss	☐ Difficulty speaking	☐ Parkinson's disease
☐ Fainting	☐ Headaches	☐ Migraines	☐ Difficulty walking
☐ Stroke	☐ Alzheimer's disease	☐ Weakness	☐ Tremors

Musculoskeletal

☐ Arthritis	☐ Arthrosis	☐ Fracture	☐ Head injury
☐ Neck injury	☐ Back injury	☐ Disc herniation	☐ Scoliosis

Endocrine

☐ Hyperthyroidism	☐ Hypothyroidism	☐ Diabetes	☐ Another hormonal problem

ENT

☐ Vision trouble	☐ Double vision	☐ Loss of hearing	☐ Tinnitus
☐ Ear pain	☐ Glaucoma	☐ Mouth problems	☐ Nosebleeds

Respiratory

☐ Asthma	☐ Cough	☐ Respiratory problems	☐ Chest pain

Other

☐ Anemia	☐ Embolism	☐ Heart attack	☐ Arrhythmia
☐ High blood pressure	☐ Low blood pressure	☐ High cholesterol	☐ Allergies: _____
☐ Heartburn	☐ Ulcers	☐ Difficulty urinating	☐ Incontinence

Men

☐ Prostate problems	☐ Erectile dysfunction	☐ Testicular problems	☐ STBI (STI)

Women

☐ Hot flashes	☐ Absent menstruation	☐ Irregular menstruation	☐ Painful menstruation
☐ Sore breasts	☐ Menopause	☐ STBI (STI)	☐ 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: _____