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 : ______________

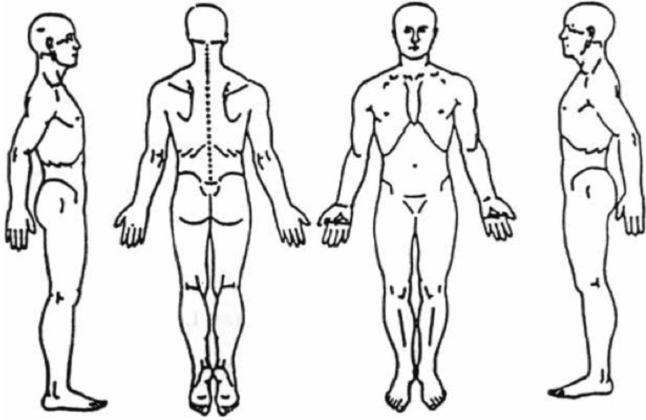
ADMISSION QUESTIONNAIRE

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: ______________