Clinique SPINECOR

▲ Date (YYYY-MM-DD)

INFORMATION

▲ Family name

▲ First name

▲ Occupation

▲ Referring physician

▲ Date of birth (YYYY-MM-DD)

▲ Address

▲ City

▲ Postal code

▲ Home phone

▲ Mobile phone

▲ Email

Gender ☐ Female ☐ Male

▲ Age ▲ Height ▲ Weight

Civil status ☐ Single ☐ Have spouse*

▲ *First and last name

Have you ever seen a chiro? ☐ Y* ☐ N

▲ *First and last name

Who referred you to us?

☐ Friend* ☐ Facebook ☐ Posturetek.com ☐ Cliniquespinecor.ca ☐ Sign
☐ Family* ☐ Other* ☐ Orthochiro.ca ☐ Other web site* ☐ Yellow Pages

▲ *Specify

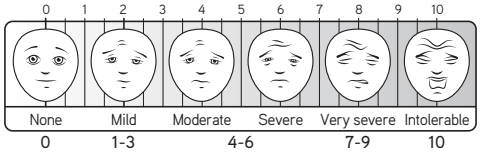
Do you have children? ☐ No ☐ Yes

▲ First name(s) ▲ Age

Do you have insurance which covers chiropractic treatments? ☐ No ☐ Yes

REASON FOR THE CONSULTATION

Pain scale:



PLEASE LEAVE SHADED AREAS BLANK

List the reasons for your consultation by order of importance.

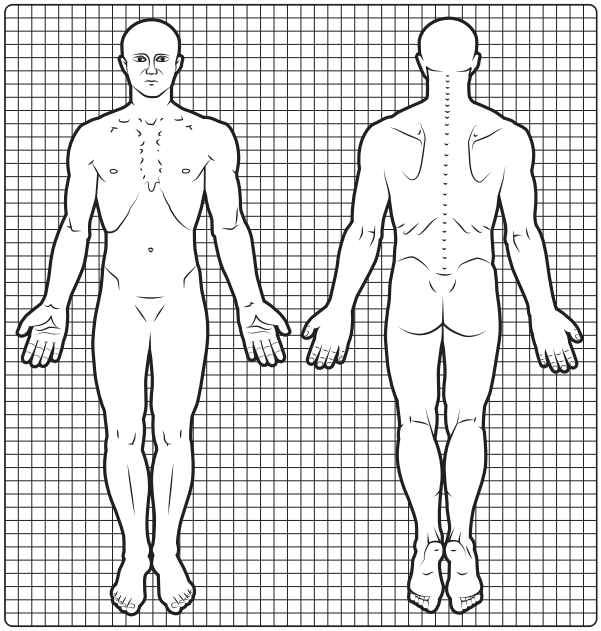
1. Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 — T ____ D ____ F ____

2. Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 — T ____ D ____ F ____

3. Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 — T ____ D ____ F ____

Is the pain spreading? ☐ No ☐ Yes, up to ____

Do you have headaches? ☐ N ☐ Yes, pain ▶ 0 1 2 3 4 5 6 7 8 9 10



Locate the reasons for your consultation (already listed at left) on the diagram by **circling** the affected area.

PERSONAL HISTORY

List your history of injuries/accidents.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____

History of surgeries and hospitalizations.

1. _____
2. _____

What other healthcare professionals have you consulted for these conditions?

1. _____ 2. _____

Please rate your stress level.

(0: no stress; 10: extreme stress)

0	1	2	3	4	5	6	7	8	9	10

Main source of stress.

_____

Do you do any physical activities/sports?

_____

▲ Specify

Cigarette consumption.

☐ No ☐ Yes ▶ _____ /week

Alcohol consumption.

☐ No ☐ Yes ▶ _____ /week

What is your working position?

- ☐ Standing
- ☐ Sitting
- ☐ In motion

Usually, you sleep on...

- ☐ Your back
- ☐ Your side
- ☐ Your stomach

What are your expectations for treatment?

- ☐ Temporary relief
- ☐ Permanent correction
- ☐ Full medical care

FAMILY MEDICAL HISTORY

Does a member of your family suffer from:

- ☐ Diabetes
- ☐ Cancer
- ☐ High cholesterol
- ☐ Osteoarthritis/arthritis
- ☐ Heart disease
- ☐ Hereditary disease
- ☐ Hyperkyphosis
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Other ▶ _____

MEDICAL HISTORY

Please check off the physical ailments you are experiencing/have experienced.

SEVERE ILLNESSES

- ☐ Cancer
- ☐ Hypertension
- ☐ Stroke
- ☐ Diabetes

MUSCULOSKELETAL SYSTEM

- ☐ Back pain
- ☐ Pain between shoulder blades
- ☐ Neck pain
- ☐ Pain in the arms/hands
- ☐ Pain in the legs/feet
- ☐ Joint stiffness
- ☐ Difficulty walking
- ☐ Scoliosis
- ☐ Hyperkyphosis
- ☐ Arthritis/osteoarthritis
- ☐ Osteoporosis

IMMUNE SYSTEM

- ☐ Otitis
- ☐ Sinusitis
- ☐ Recurring infections

GENITOURINARY SYSTEM

- ☐ Urinary tract infection
- ☐ Frequent/excessive urination
- ☐ Prostate disorder
- ☐ Urinary loss
- ☐ Incontinence
- ☐ Menstrual pain
- ☐ Breast pain/lump
- ☐ Menopause
- ☐ Pregnant ▼

_____

▲ Date of your last period

NERVOUS SYSTEM

- ☐ Muscle weakness
- ☐ Dizziness/vertigo
- ☐ Fainting
- ☐ Epilepsy
- ☐ Numbness

GENERAL

- ☐ Insomnia
- ☐ Fatigue
- ☐ Thyroid disorder
- ☐ Anxiety/depression
- ☐ Allergies*

_____

▲ *Specify

PLEASE LEAVE SHADED AREAS BLANK

GASTROINTESTINAL SYSTEM

- ☐ Digestive problems
- ☐ Food intolerance
- ☐ Irritable bowel syndrome
- ☐ Diarrhea
- ☐ Bloating
- ☐ Heart burn
- ☐ Excessive weight gain or loss

SKIN

- ☐ Eczema
- ☐ Psoriasis

RESPIRATORY SYSTEM

- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of breath

CARDIOVASCULAR SYSTEM

- ☐ Chest pain
- ☐ Heart problems
- ☐ Edema
- ☐ Cold extremities
- ☐ Varices
- ☐ High cholesterol

_____

_____

_____

Do you take any medications? ☐ N ☐ Y*

_____

▲ *For which of the above conditions? (or circle)

Do you take any dietary supplements? ☐ N ☐ Y*

_____

▲ *Specify?

When is your next medical checkup?

_____

DECLARATION (mandatory for all)

I declare that all information provided in this form is complete and acurate and agree to undergo any required medical examinations.

_____ ▲ Signature

_____ ▲ Date