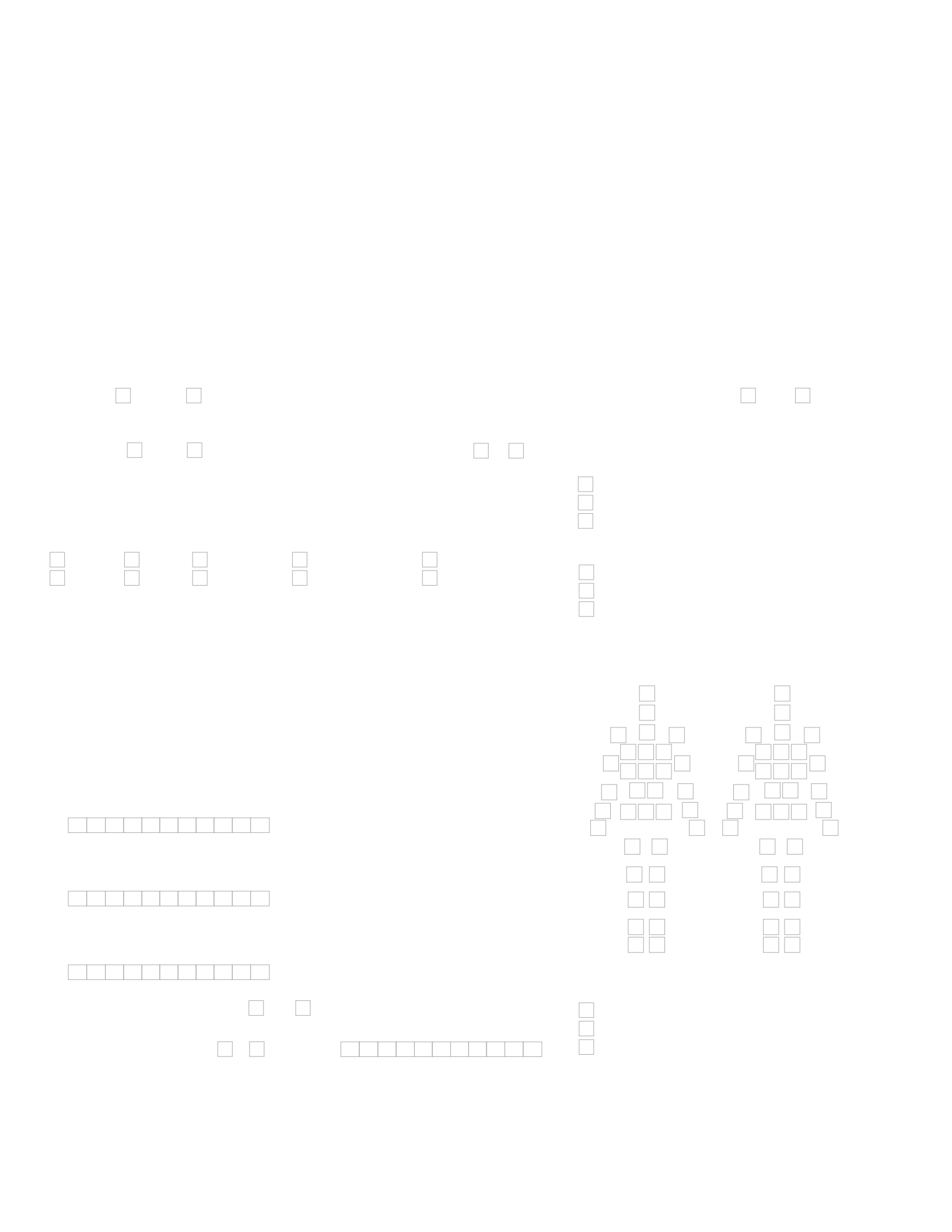

PERSONAL HISTORY

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

FAMILY MEDICAL HISTORY

Specify: F = Father M = Mother B = Brother S = Sister

Does a member of your family suffer from:

Diabetes ___ High cholesterol ___ Trouble cardiaque ___ Hyperkyphosis ___ Osteoarthritis/arthritis ___

Cancer ___ Scoliosis ___ Hereditary disease ___ Osteoporosis ___ Other ▶ _____

MEDICAL HISTORY

PLEASE LEAVE SHADED AREAS BLANK

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
- ☐ Allergies*

_____

▲ *Specify

GASTROINTESTINAL SYSTEM

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

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

GENERAL

- ☐ Insomnia
- ☐ Fatigue
- ☐ Thyroid disorder

NERVOUS SYSTEM

- ☐ Muscle weakness
- ☐ Dizziness/vertigo
- ☐ Fainting
- ☐ Epilepsy
- ☐ Numbness
- ☐ Memory loss
- ☐ Anxiety/depression

SKIN

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

RESPIRATORY SYSTEM

- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of breath

CARDIOVASCULAR SYSTEM

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

_____

_____

Do you take any medications? ☐ Y ☐ N

- ☐ Anti-inflammatory
- ☐ Muscle relaxant
- ☐ Thyroid gland
- ☐ Analgesic
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cholesterol
- ☐ Birth control
- ☐ Antidepressant
- ☐ Anxiolytic
- ☐ Other _____

Do you take any dietary supplements? ☐ Y ☐ N

- ☐ Vitamins _____
- ☐ Omega-3 _____
- ☐ Minerals _____
- ☐ Proteins _____
- ☐ Homeopathy _____
- ☐ Naturopathy _____
- ☐ Other _____

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. I hereby declare that I agree that my clinical data and Xrays might be used anonymously for scientific research and educational purposes.

_____ ▲ Signature

_____ ▲ Date