Simply Chiropractic

Phone Number : 613 520-0123

Family Name :	Given Name :
Date of birth : Day / Month / Year	City: / Province:
Address :	Postal code :
Email:	Cell phone :
Home phone :	Work phone :
Referred by :	Occupation :

Name of husband / spouse :________________ Number of children: ________ Children's age :___ ___ ___

Personal health insurance : _______________________ Family plan ☐ Individual plan ☐

CURRENT HEALTH CONDITION

List your chief complaints in order of severity :

1.____ For how long? ___________________________

2.____ For how long? ___________________________

3.____ For how long? ___________________________

Does the pain spread ? No ☐ Yes ☐ where ?__________________

Do you have numbness ? No ☐ Yes ☐ where ?__________________

Are there some movements or positions that make the pain worst ? No ☐ Yes ☐

Sitting ☐ Standing ☐ Leaning ☐ Lying down ☐ Other_________________________

Have you ever seen other doctors for this condition? No ☐ Yes ☐

If yes, who?____

Type of treatment : ____________________ Any Results? ____________________________

Past chiropractic cares No ☐ Yes ☐

Name of the chiropractor : _______________________ Date of the last treatment :____________________

Drugs taken at this moment

☐ Analgesics ☐ Anti-inflammatories ☐ Hormones

☐ Muscular relaxers ☐ High blood pressure tranquilizers ☐ Contraceptive pill

☐ Anti-pain ☐ Insuline ☐ Other/precise :______________

Sleeping position Back ☐ Stomach ☐ Sides ☐

Accidents / Major fall /coma

☐ Car accident Date_______________________ Date_______________________

☐ Major fall Date_______________________ Date_______________________

☐ Cerebral concussion/ Coma Date_______________________ Date_______________________

☐ Repetitive movements _______________________

PAST HEALTH HISTORY

Please check ☑ any of the following diseases you have had

☐ Pneumonia	☐ Thyroid	☐ Diabetes	☐ Anemia
☐ Rheumatic Fever	☐ Tuberculosis	☐ Cancer	☐ Polio
☐ Epilepsy	☐ Arthritis	☐ Alcoholism	

MAJOR SURGERIES/ HOSPITALISATIONS

☐ Appendicitis	☐ Gallbladder	☐ Back surgery
☐ Tonsil	☐ Hysterectomy	☐ Other-Precise :___________________
☐ Fractures		

MUSCULAR -SKELETAL

☐ Low back pain	☐ Pain between the shoulders	☐ Joint pain/Stiffness/Swelling
☐ Arm pain	☐ Sciatic nerve	☐ Cold hands and feet
☐ Neck pain	☐ Scoliosis	☐ Bursitis
☐ Difficulties to walk	☐ Stiffness in general	

NERVOUS SYSTEM

☐ Nervosity	☐ Dizziness	☐ Stress	☐ Depression/confusion
☐ Numbness	☐ Convulsion	☐ Paralysis	

GENERAL

☐ Allergies	☐ Insomnia	☐ Sinusitis	☐ Bad blood circulation
☐ Tiredness	☐ Chronic bronchitis	☐ Asthma	
☐ Headaches	☐ Migraines	☐ Hay fever	

GASTRO-INTESTINAL

☐ Chronic diarrhoea	☐ Haemorrhoids	☐ Indigestion	☐ Frequent nausea
☐ Liver problem	☐ Gallbladder problems	☐ Ulcers	

GENITAL-URINARY	☐ Painful/excessive urinary	☐ Incontinence
EYES/EAR/ NOSE/THROAT	☐ Hum	☐ Tinnitus
	☐ Otitis	☐ Hearing difficulty

CARDIO-VASCULAR

☐ Chest pain	☐ Phlebitis	☐ Low blood pressure
☐ Angina	☐ Congested lungs	☐ Palpitations/ High blood pressure
☐ Infarct	☐ Swelling ankle	☐ Short breath

FAMILY HISTORY No Yes Father Mother Sister Brother Grand-parents Other______________

WOMEN ONLY When was your last period? : __________ Are you pregnant? : Yes No Maybe

☐ P.M.S	☐ Breast pain	☐ Bumps on breast	M.T.S.____________
☐ Excessive bleeding	☐ No menstrual	☐ Heat flash	Aids
☐ Menstrual irregularity	☐ Menstrual cramps	☐ Vaginites	Other _____________
MEN ONLY	☐ Erective problems	☐ Prostate problems	M.T.S_____________

______________________________________ ___________________

Patient's Signature/ curator ***Date***