CENTRE CHIRO-EXPRESS

Please complete this questionnaire properly. It will allow our professionals to know you better and to offer you the best care.

Last name :________________ First name:____________________ Sex : F ☐ M ☐

Address:____ Birth date: yr______/mo _____/d____

____ Married ☐ Single ☐ Widow ☐ Div. ☐

City:____________________ Postal code____________ Occupation: ________________________

Phone (H)_________________ (W)_________________ ______________________________

E-Mail : ____

Do you have insurance that covers Chiropractic care? Yes ☐ No ☐ Do not know ☐

Who recommended you to our clinic? Friend ☐ Family ☐ Yellow Pages ☐ Outside sign ☐ Publicity ☐ Other ☐

1. What is the reason for your consultation ? Please list your health problems in order of importance:

____

____

____

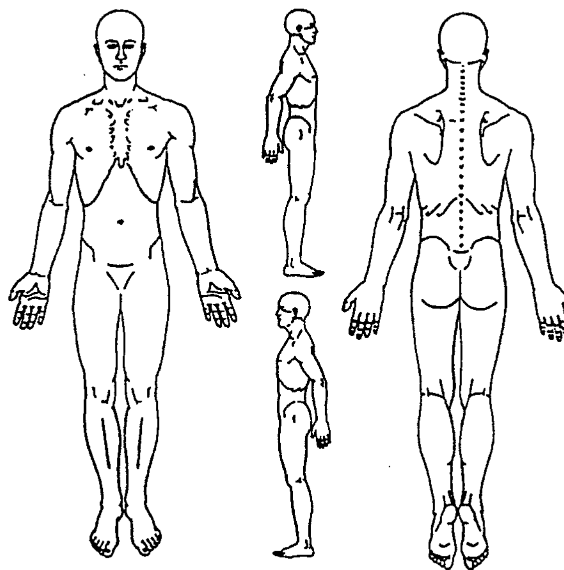
____

2. Since when have you had your main problem?

____

3. How did your main problem appear?
   - Gradually ☐ Suddenly ☐
   - Accident/trauma ☐ Do not know ☐
4. Is your problem present...?
   - 100% of the time ☐ 50% of the time ☐
   - 75% of the time ☐ 25% of the time ☐
5. Is your problem getting
   - Better ☐
   - Worse ☐
   - Staying the same ☐
6. Is your problem worse
   - Morning ☐ Evening ☐
   - Day ☐ Night ☐
7. Does your problem keep you from...?
   - Working ☐ Sleeping ☐ Your daily routine ☐
8. Have you seen another health professional for your problem ?
   - Yes ☐ No ☐
   - Chiropractor ☐ name?________________
   - Medical ☐
   - Other ☐
9. Have you had your main problem before ?
   - Yes ☐ No ☐
10. Have you ever been diagnosed with cancer?
    - Yes ☐ No ☐
    - If so, which type of cancer? ________________

Please indicate on the drawings, the exact location of your problems.



Check the box that indicates the severity of your main problem.

No Pain **Severe Pain**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

Date of your last examination:

	Less than 6 mos	6-18 mos	More than 18 mos	Never
Chiropractic	☐	☐	☐	☐
Physical	☐	☐	☐	☐
Radiological	☐	☐	☐	☐
Blood	☐	☐	☐	☐
Urine	☐	☐	☐	☐

FAMILY HISTORY:

1- Father: Age_______ If deceased, cause______________

2 - Mother: Age_______ If deceased, cause ______________

3 - Do you have brothers or sisters? Yes ☐ No ☐

4- Do members of your family suffer from

Cardiac problems ☐ Cancer ☐

Arthritis ☐ Diabetes ☐

Others (be specific) ☐ ______________

Are you taking any medication at this time?

No ☐ Yes ☐

- Anti-inflammatory ☐
- Pain killers ☐
- Relaxants ☐
- Hormones ☐
- Insulin ☐
- For high blood pressure ☐
- For the thyroid gland ☐
- « The Pill » ☐
- Other ______________________

A- What is your work position?

Standing ☐ Sitting ☐ Moving ☐

B- Do you wear...?

A heel lift ☐

Shoe orthotics ☐

C- Do you usually sleep on your...?

Back ☐ Side ☐ Stomach ☐

D- How many hours do you sleep at night?

4h or less ☐ 9-10h ☐

5-6h ☐ 10-11h ☐

7-8h ☐ 12h or more ☐

E- Do you consume ...? If yes how many?

1- Tobacco/cigarettes Yes ☐ No ☐____

2- Alcohol Yes ☐ No ☐____

3- Coffee/tea Yes ☐ No ☐____

4- Vitamins and supplements Yes ☐ No☐

If yes, which ones? ________________

F- Do you exercise?

Yes ☐ No ☐

HAVE YOU HAD (○) OR DO YOU HAVE (☐) ANY OF THE FOLLOWING PROBLEMS:

Mark the appropriate symbol

1. ○ ☐ Allergies
2. ○ ☐ Anxiety
3. ○ ☐ Arthritis
4. ○ ☐ Abdominal gas
5. ○ ☐ Low blood pressure
6. ○ ☐ Constipation
7. ○ ☐ Convulsions
8. ○ ☐ Itching
9. ○ ☐ Depression
10. ○ ☐ Diabetes
11. ○ ☐ Diarrhea
12. ○ ☐ Easily bruised
13. ○ ☐ Numbness
14. ○ ☐ Epilepsy
15. ○ ☐ Skin eruptions (redness)
16. ○ ☐ Dizziness/vertigo
17. ○ ☐ Loss of consciousness
18. ○ ☐ Cold extremities
19. ○ ☐ Fatigue
20. ○ ☐ Fractures
21. ○ ☐ Shivers
22. ○ ☐ High blood pressure
23. ○ ☐ Hypoglycemia
24. ○ ☐ Urinary incontinence
25. ○ ☐ Insomnia
26. ○ ☐ Irritability
27. ○ ☐ Hereditary diseases
28. ○ ☐ Back pain
29. ○ ☐ Headaches
30. ○ ☐ Meningitis
31. ○ ☐ Edema (swelling)
32. ○ ☐ Operations/surgery
33. ○ ☐ Loss or gain of weight
34. ○ ☐ Kidney stones
35. ○ ☐ Shaking
36. ○ ☐ Foot problems
37. ○ ☐ Cardiac problems
38. ○ ☐ Poor blood circulation
39. ○ ☐ Respiratory problems
40. ○ ☐ Eye problems
41. ○ ☐ Digestive problems
42. ○ ☐ Sexual problems
43. ○ ☐ Hearing problems
44. ○ ☐ Hormonal problems
45. ○ ☐ Psychological problems
46. ○ ☐ Kidney problems
47. ○ ☐ Varicose veins
48. ○ ☐ Nose bleeds
49. ○ ☐ Blood in the stools
50. ○ ☐ Blood in the urine
51. ○ ☐ Sinusitis
52. ○ ☐ Urinate frequently
53. ○ ☐ Urinate at night
54. ○ ☐ Prostate problems

SECTION RESERVED FOR WOMEN

55. ○ ☐ No menstruation
56. ○ ☐ Abdominal cramps
57. ○ ☐ Abundant menstrual flow
58. ○ ☐ Painful menstruation
59. ○ ☐ Vaginal loss
60. ○ ☐ Menopause symptoms
61. Are you pregnant? Yes ☐ No ☐

PAYMENTS

X-ray films, examination and chiropractic treatments are payable at each visit, unless prior financial arrangements have been made. **X-ray films remain the property of the clinic.**

DECLARATION FOR ALL

I declare that the information given on this form is complete and exact and I consent to receive any necessary examinations.

SIGNATURE: ______________________________ **DATE:** ____________________