Kirkland Chiro-Health Clinic — Opening File (Adults)

Name: _____ Gender: _____ Date of birth: _____

Address: _____ Occupation: _____

City: _____ Do you have insurance that covers chiropractic care?_____

Province: _____ Postal code: _____ Home Phone: _____ Cell Phone: _____

Emergency contact (name and phone): _____

Who recommended us? Friend: ☐ Family: ☐ Internet: ☐ Name: _____

E-Mail Address: _____ Consent to be contacted by e-mail (confirmations/receipts): ☐

1) What is the reason for your consultation?
Please list your issues in order of importance:

a) _____

b) _____

c) _____

2) Since when have you had your main problem? _____

3) How did your main problem appear?

Gradually: ☐ Suddenly: ☐ Accident: ☐
Do not know: ☐

4) Is your problem present...?

100% of the time: ☐ 75% of the time: ☐ 50% of the time: ☐
25% of the time: ☐ Less than 25% of the time: ☐

5) Is your problem getting...?

Better: ☐ Worse: ☐ Staying the same: ☐

6) Is your problem worse...?

Morning: ☐ Day: ☐ Evening: ☐ Night: ☐

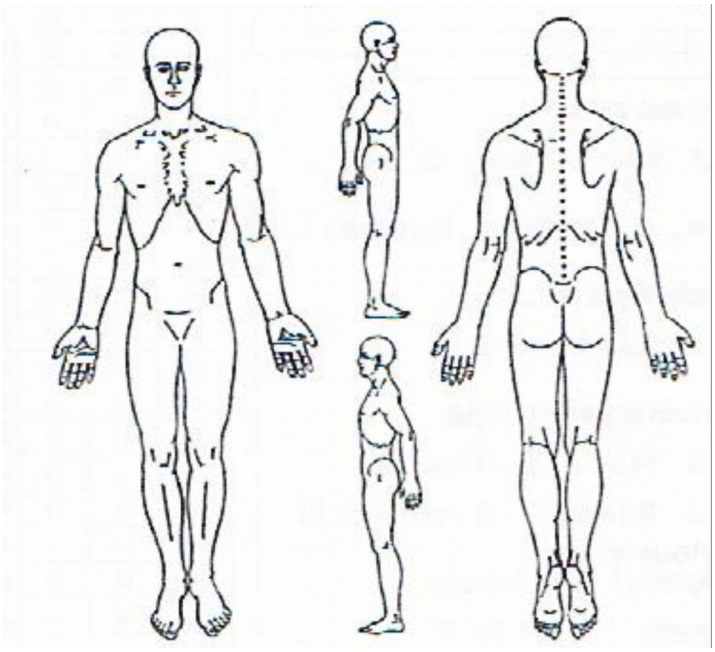
7) Does your problem keep you from...?

Working: ☐ Sleeping: ☐ Your daily routine: ☐

8) Have you seen another health professional for your problem? No: ☐ Chiropractor: ☐ Medical: ☐ Other: ☐

9) Have you had your main problem before? No: ☐
Yes: ☐ When? _____

Please indicate on the drawing the exact location(s) of your problem(s).



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

No Pain — Extreme 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	☐	☐	☐	☐

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FAMILY HISTORY

Do any members of your family have: Cardiac problems: ☐
Cancer: ☐ Diabetes: ☐ Arthritis: ☐ Other: ☐

Father's age: _____ If deceased, cause: _____

List other (if any): _____

Mother's age: _____ If deceased, cause: _____

_____

Additionnal info (if any): _____

Are you taking any medication at this time?

No: ☐ Muscular relaxants: ☐

Anti-inflammatory: ☐ Pain killers: ☐

Anti-coagulants: ☐ Hormones: ☐ Insulin: ☐

High blood pressure: ☐ Diabetes: ☐

Thyroid gland: ☐ "The Pill": ☐

Other: ☐ _____

1) What is your work position?

Standing: ☐ Sitting: ☐ Moving: ☐

2) Do you wear... ? A heel lift: ☐ Shoe Orthotics: ☐

3) Do you usually sleep on your... ?

Back: ☐ Side: ☐ Stomach: ☐

4) How many hours do you sleep at night?

4 hours or less: ☐ 5-6 hours: ☐ 7-8 hours: ☐

9-10 hours: ☐ 10-11 hours: ☐ 12 or more hours: ☐

5) Do you consume...? If yes, how many?

a) Tobacco/cigarettes: No: ☐ Yes: ☐ _____

b) Alchol: No: ☐ Yes: ☐ _____

c) Coffee/Tea: No: ☐ Yes: ☐ _____

d) Do you take vitamins or supplements?

No: ☐ Yes: ☐ What: _____

6) Do you exercise? No: ☐ Yes: ☐

Have you had or do you have any of the following problems?

	Yes	No			Yes	No	
1)	☐	☐	Allergies	33)	☐	☐	Weight loss or gain
2)	☐	☐	Anxiety	34)	☐	☐	Kidney stones
3)	☐	☐	Arthritis	35)	☐	☐	Trembling
4)	☐	☐	Abdominal pain	36)	☐	☐	Foot problems
5)	☐	☐	Low blood pressure	37)	☐	☐	Cardiac problems
6)	☐	☐	Constipation	38)	☐	☐	Poor circulation
7)	☐	☐	Convulsions	39)	☐	☐	Respiratory problems
8)	☐	☐	Itching	40)	☐	☐	Eye problems
9)	☐	☐	Depression	41)	☐	☐	Digestive problems
10)	☐	☐	Diabetes	42)	☐	☐	Sexual problems
11)	☐	☐	Diarrhea	43)	☐	☐	Hearing problems
12)	☐	☐	Easily bruised	44)	☐	☐	Hormonal problems
13)	☐	☐	Numbness	45)	☐	☐	Psychological problems
14)	☐	☐	Epilepsy	46)	☐	☐	Kidney problems
15)	☐	☐	Skin eruptions (redness)	47)	☐	☐	Varicose veins problems
16)	☐	☐	Dizzieness/Vertigo	48)	☐	☐	Nose bleeds
17)	☐	☐	Loss of consciousness	49)	☐	☐	Blood in the stool
18)	☐	☐	Cold extremities	50)	☐	☐	Blood in the urine
19)	☐	☐	Fatigue	51)	☐	☐	Sinusitis
20)	☐	☐	Fractures	52)	☐	☐	Urinate frequently
21)	☐	☐	Shivers	53)	☐	☐	Urinate at night
22)	☐	☐	High blood pressure	54)	☐	☐	Prostate problems
23)	☐	☐	Hypoglycemia	55)	☐	☐	Cancer
24)	☐	☐	Urinary incontinence				
25)	☐	☐	Insomnia				
26)	☐	☐	Irritability				
27)	☐	☐	Hereditary diseases				
28)	☐	☐	Back pain				
29)	☐	☐	Headaches				
30)	☐	☐	Meningitis				
31)	☐	☐	Edema (sw elling)				
32)	☐	☐	Operations/Surgery				

Section reserved for Women

56)	☐	☐	No menstruation
57)	☐	☐	Abdominal pain
58)	☐	☐	Abundant menstrual flow
59)	☐	☐	Painful menstruation
60)	☐	☐	Vaginal loss
61)	☐	☐	Menaupause symptoms
62)	Are you pregnant? Yes: ☐ No: ☐ Maybe: ☐		

PAYMENTS:

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

CONSENT:

I agree that the clinic may verbally disclose appointment dates and charges for treatments to my insurer: ☐

DECLARATION FOR ALL:

I hereby declare that the information provided is accurate and complete. I consent to receive any necessary examinations.

Date: _____ Signature: _____