Chiro-Santé Kirkland Clinic

Opening File (Adults)

Name: _____ Gender: _____ Date of Birth: _____

Address: _____ Married: ❑ Single: ❑ Widowed: ❑ Divorced: ❑ Common Law: ❑

City: _____ Occupation: _____

Province: _____ Postal Code: _____ Do you have insurance that covers chiropractic care? _____

E-mail address: _____ Who recommended our clinic to you? Friend: ❑ Family: ❑ Internet: ❑

Home Phone: _____ Cell Phone: _____ Who recommended us? _____

1) What is the reason for your consultation? Please list your health 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 then 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 ❑

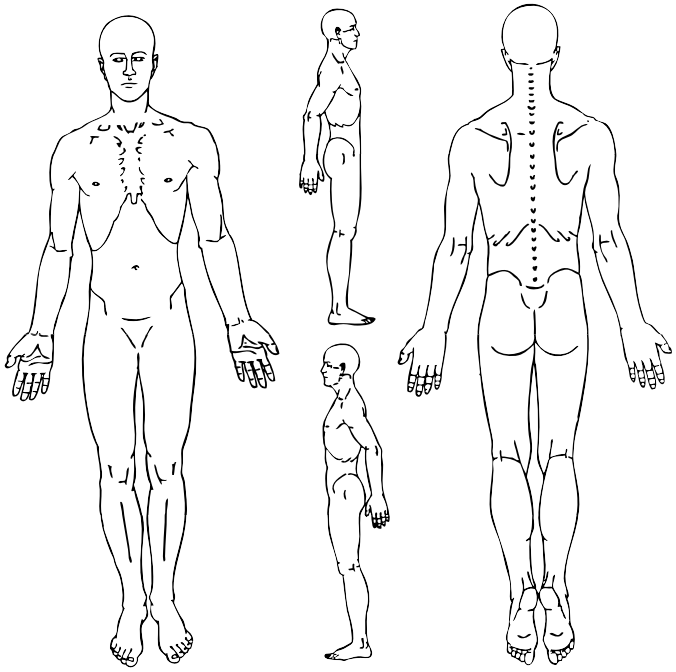
8) Have you seen another health professional for your problem?

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 you last examination:

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

FAMILY HISTORY

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

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

Do you have any brothers or sisters? Yes: ❑ No: ❑

Do any members of your family have: Cardiac Problems: ❑

Cancer: ❑ Diabetes: ❑ Arthritis: ❑ Other: ❑

List other (if any): _____

_____

Are you taking any medication at this time?

No: ❑ Muscular Relaxants: ❑ Anti-inflammatory: ❑ Pain Killers: ❑

Anti-coagulants: ❑ Hormones: ❑ Insulin: ❑

For high blood pressure: ❑ Diabetes: ❑

For the 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 and 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) Alcohol 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)	❑	❑	Dizziness/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 (Swelling)				
32)	❑	❑	Operations/Surgery				

Section Reserved for Women			
56)	❑	❑	No Menstruation
57)	❑	❑	Abdominal Pains
58)	❑	❑	Abundant Menstrual Flow
59)	❑	❑	Painful Menstruation
60)	❑	❑	Vaginal Loss
61)	❑	❑	Menopause 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.

DECLARATION FOR ALL:

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

Date: _____ Signature: _____