ORTHO CHIRO

▲ Date (YYYY-MM-DD)

INFORMATION

▲ Family name
▲ First name
▲ Occupation
▲ Referring physician
▲ Date of birth (YYYY-MM-DD)
▲ Address
▲ City
▲ Postal code
▲ Home phone
▲ Mobile phone
▲ Email

Gender ◯ Female ◯ Male

▲ Age ▲ Height ▲ Weight

Do you have children? ◯ No ◯ Yes

Age

Civil status ◯ Single ◯ Have spouse*

▲ *First and last name

Have you ever seen a chiro? ◯ Y* ◯ N

▲ *First and last name

What is your working position?

◯ Standing
◯ Sitting
◯ In motion

Who referred you to us?

◯ Friend* ◯ Google ◯ Facebook ◯ Cliniquespinecor.ca ◯ Window display
◯ Family* ◯ Other* ◯ Orthochiro.ca ◯ Other website* ◯ Other professionnal

▲ *Specify

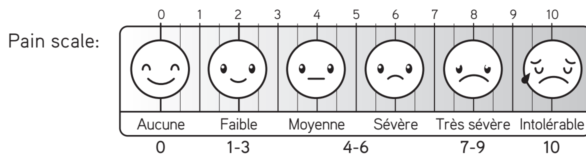
Usually, you sleep on...

◯ Your back
◯ Your side
◯ Your szztomach

REASON FOR THE CONSULTATION

PLEASE LEAVE SHADED AREAS BLANK

Pain scale:



List the reasons for your consultation by order of importance.

1.
Pain ▼ 0 1 2 3 4 5 6 7 8 9 10
T D F

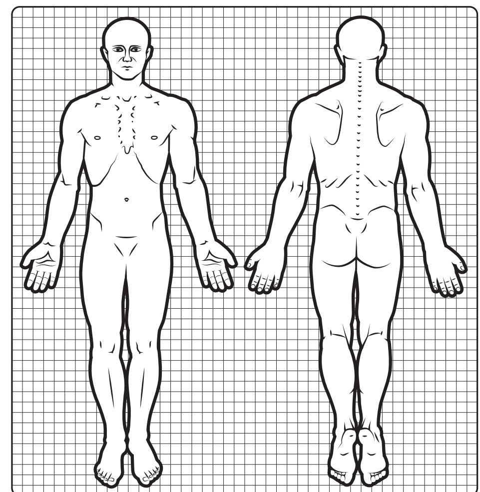
2.
Pain ▼ 0 1 2 3 4 5 6 7 8 9 10
T D F

3.
Pain ▼ 0 1 2 3 4 5 6 7 8 9 10
T D F

Is the pain spreading? ◯ No ◯ Yes, up to

Do you have headaches? ◯ N ◯ Yes, pain ▶ 0 1 2 3 4 5 6 7 8 9 10

Circle the painful areas.



What are your expectations for treatment?

◯ Temporary relief
◯ Permanent correction
◯ Full medical care

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 ___ Maladie héréditaire ___ 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? ☐ N ☐ Y*

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

Do you take any dietary supplements? ☐ N ☐ Y*

- ☐ 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 ______________