HEALTH HISTORY

First Name : _____ Sex : F ☐ M ☐ Other _____

Name : _____ Birth Date : _____/_____/_____
Day Month Year

Adress : _____

City : _____ Do you live : Alone ☐ Spouse ☐ Family ☐

Postal Code : _____ Home : ( ) _____

Cell : ( ) _____ Work : ( ) _____ Occupation : _____

Email Adress : _____ Full Time ☐ Part Time ☐ Seasonal ☐

Who referred you to our office? Friend or Family ☐ Professionnal ☐ Yellow Pages/Google ☐ Ad ☐ Other ☐

His/Her name : _____

– Family Physician : _____

– Did you consult another health professional for this condition? Yes ☐ No ☐

Which one(s)? Chiropractor ☐ Medical Doctor ☐
Physio ☐ Osteopath ☐ Other ☐

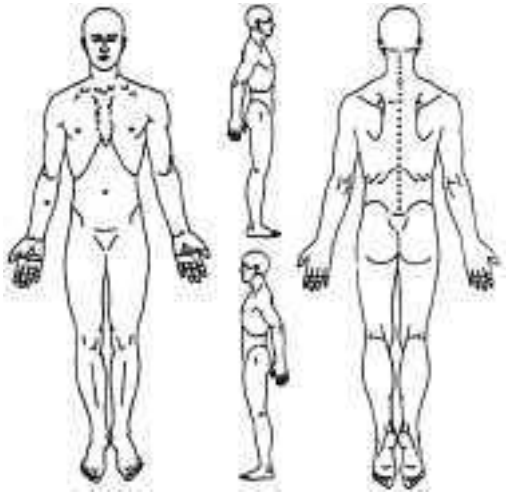
Their name(s) : _____

– List all medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____

PLEASE INDICATE ON THE DRAWING
ALL AREAS OF CONCERN
State pain level where applicable

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



– List all accidents, surgeries and health problems, current or past :

_____
_____
_____
_____
_____

FAMILY HISTORY :

– Father : Age ____ if deceased, cause_____

– Mother : Age ____ if deceased, cause_____

– Do you have siblings? Yes ☐ No ☐

– Do you have children? Yes ☐ No ☐

If yes, please indicate their age : _____

– Is a member of your family suffering from :

☐ Heart disease
☐ Cancer : _____
☐ Diabetes
☐ Arthritis / Arthrosis
☐ High blood pressure
☐ Other _____

– What is your work position? ☐ Standing ☐ Sitting ☐ Moving

– Are you wearing or have you had in the past? ☐ Heel lift ☐ Orthotic ☐ Contact lenses
☐ IUD ☐ Pacemaker ☐ Dentures ☐ Braces

– Usually, are you sleeping on your...? ☐ Back ☐ Side ☐ Stomach

– How many hours do you sleep at night? - ◉ 4h ○ 5h ○ 6h ○ 7h ○ 8h ○ 9h ○ 10h ○ +

– Do you wake up rested? Yes

– What is your stress level? ○ None ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ Unbearable

– Are you using...? If yes, how much

Tobacco / Cigarettes	_____ / day	Vegetables	_____ / day
Alcool	_____ / week	Fruits	_____ / day
Coffee / Tea	_____ / day	Meat	_____ / week
Soda	_____ / day	Fish	_____ / week
Water	_____ / day	Dairy	_____ / week

Vitamins and/or Supplements Yes ☐ No ☐
which one(s) : _____

– Are you exercising? Yes ☐ No ☐ How many hours a week : _____
which sport(s) : _____

– Are you pregnant or do you think you might be? Yes ☐ No ☐

To insure the best care possible , we want to evaluate your level of health. Please check the box that corresponds to the frequency of the symptom. If you have never experienced these, leave the line blank.

Sometimes	Often	Continuous	
☐	☐	☐	Neck pain
☐	☐	☐	Mid back pain
☐	☐	☐	Low back pain
☐	☐	☐	Leg pain
☐	☐	☐	Arm/hand pain
☐	☐	☐	Irritability
☐	☐	☐	Anxiety
☐	☐	☐	Depression
☐	☐	☐	Fatigue
☐	☐	☐	Insomnia
☐	☐	☐	Memory difficulty
☐	☐	☐	_____
☐	☐	☐	_____

Sometimes	Often	Continuous	
			Numbness :
☐	☐	☐	arm / hand
☐	☐	☐	leg / foot
☐	☐	☐	face
☐	☐	☐	Vertigo
☐	☐	☐	Fainting
☐	☐	☐	Headaches
☐	☐	☐	Eye pain
☐	☐	☐	Double vision
☐	☐	☐	Loss of hearing
☐	☐	☐	Ear pain
☐	☐	☐	Shaking
☐	☐	☐	Weakness
☐	☐	☐	Night sweat

Sometimes	Often	Continuous	
☐	☐	☐	Shortness of breath
☐	☐	☐	Chest pain
☐	☐	☐	Swelling
☐	☐	☐	Allergies _____
☐	☐	☐	Digestive problems
☐	☐	☐	Nausea
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Loss of appetite
☐	☐	☐	Sudden weight change
☐	☐	☐	Urinary problems
☐	☐	☐	Menstrual problems
☐	☐	☐	STD

DECLARATION

I, hereby authorize the chiropractor to conduct the exams deemed necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally don't last long, it is important to mention them to your chiropractor at your next appointment.

Signature : _____ **Date :** _____