CONFIDENTIAL QUESTIONNAIRE

A

Last name: _____ Name: _____ Date of birth: _____ Sex: F M Marital status: _____

Address: _____ City: _____ Postal code: _____ Tel. home: ( )_____

Tel. work: _____ Cell phone: _____ E-mail: _____

Occupation: _____ Refered by: _____

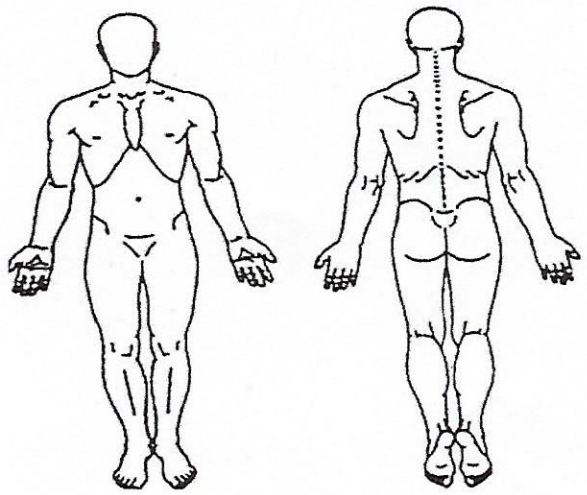
B

Complaint history

1. **What is your major reason for consultation**
   ❑ Prevention ❑ Health improvement ❑ Particular problem:
   _____
   Others: _____
2. **When did the problem appear?**_____
   Describe how it happended? _____
   _____
3. **Is this the first episode? ❑ Yes ❑ No ___th time**
4. **Describe your pain and/or the symptoms associated**
   ❑ *sharp* ❑ *aching* ❑ *burning* ❑ *tension/tightening* ❑ *blocking*
   ❑ *pins and needles* ❑ *radiating* ❑ *diffuse* ❑ *stabbing* ❑ *weakness*
   ❑ *numbness* ❑ *Other:*_____
5. **Circle the intensity (none) 0 1 2 3 4 5 6 7 8 9 10 (very strong)**
6. **Your pain or symptom is present _____days / week**
   ❑ Constant ❑ Intermittent
   worse in the: ❑ Morning ❑ Day ❑ Evening ❑ Night
   releaved by: ❑ Rest ❑ Changing positions ❑ Warmth/cold
   ❑Walking ❑ Sitting ❑ Lying ❑ Standing
   ❑ Medication:_____
   ❑ Others _____
7. **Your condition tends to worsen**
   ❑ With time ❑ Which each episode
   ❑ With certain movements: _____
   ❑ After certain activities: _____
8. **Your condition limites you in which activity?**
   ❑ Work ❑ Sleep ❑ Walk ❑ Sports ❑ Leisure activities
   ❑ Every day routine: _____
9. **Which causes : ❑ lower energy ❑ Increased tension, stress**

Indicate the exact location of your problems

Pain: **XXXXX** Numbness: ////// Tighteness: --------



- Have you ever consulted any other professionnal for your present condition or a similar condition?
  ❑ Yes:_____ ❑ No
  Diagnostic: _____
  Results:❑ Very good ❑ Some improvement ❑ None/worse
- Is your case handled by the CSST? ❑ Yes ❑ No
- Is your case handled by the SAAQ? ❑ Yes ❑ No
- Which activities do you wish to enjoy more when you are in better health?
  _____

C

Spinal health history

1. **Which of these potential causes of vertebral disorders have you experienced?**
   - Vehicle accident ❑ Yes ❑ No
     Date: _____
     _____
   - Accidental falls ❑ Yes ❑ No
   - Strenuous efforts ❑ Yes ❑ No
   - Contact sports ❑ Yes ❑ No
   - Repetitive movements ❑ Yes ❑ No
   - Sustained poor posture ❑ Yes ❑ No
2. **What is your level of stress?**
   ❑ None ❑ Low ❑ Moderate ❑ High ❑ Extreme
3. **When was your last chiropractic exam?**_____
4. **What was the name of the chiropractor?** _____
5. **What type of care have you received?**
   ❑ Relief ❑ Corrective ❑ Preventive
6. **What approach or technique was used?**
   ❑ Adjustments ❑ Ultrasounds, electric stimulation ❑ Massage
7. **Have you had any X-Rays this year?**
   ❑ Yes (of which area? _____) ❑ No

D

Habits

1. Have you participated in any physical activities during the past six months? ❑ Yes: _____ ❑ No
2. Computer/office work:___h/day standing:_____h/day
   lifting weights:___h/day repetitive mouvements:____h/day
3. Is your working area ergonomic?: ❑ Yes ❑ No
4. Diet : ❑ Poor ❑ Acceptable ❑ Good ❑ Excellent
5. Tabacco: ___ / day Alcohol: ___ / weak
   Tea, coffee: ___ / day Soft drink: ___ / day
6. Sleep: ❑ Refreshing ❑ Non refreshing
   Position: ❑ Stomach ❑ Back ❑ Side
   Adequate mattress : ❑ Yes ❑ No
   Orthopaedic pillow: ❑ Yes ❑ No

E

Section for women only

1. Are you pregnant? ❑ Yes ❑ No ❑ Don't know
2. Your periods are: ❑ Irregular ❑ Painfull ❑ Abundant
3. Contraceptive method: _____
4. Are you menopausal? ❑ Yes ❑ No
5. Are you on hormone therapy? ❑ Yes ❑ No
6. Have you noticed : ❑ A mass on your breast
   ❑ Abnormal vaginal secretions
7. Number of pregnancies:____ Complications:_____

CONFIDENTIAL QUESTIONNAIRE

F

Health history

1. Your birth was :
   ❑ By caesarean ❑ With complications
2. Are you ❑ Right handed ❑ Left handed?
3. Have you ever been:
   ❑ Hospitalized?_____ Year:_____
   ❑Operated? _____ Year:_____
   _____ Year:_____
   ❑ Sick? _____ Year:_____
   ❑ Suffer from a trauma / fracture?_____
   _____ Year:_____
4. Are you presently taking any medication? ❑ No ❑ Yes
   specify:_____
   _____
5. Are you taking vitamins or other natural products? ❑ No
   ❑ Yes, which ones:_____
6. Do you have : ❑ Foot orthotics?
   ❑ Breast implants?
   ❑ Joint prosthesis ?
   ❑ Lombar support or cervical collar?
7. Do you have any personal subjects that you wish to discuss in confidentiality with your chiropractor? ❑ Yes ❑ No
8. Name of your medical doctor:_____
9. Your weight: _____ Your height _____

Family history

1. Do your parents suffer from vertebral problems? ❑ Yes ❑ No
2. How many children do you have? _____ How old?: _____
3. Does anybody in your family suffer from degenerative illnesses?
   • arthrosis ___ • arthritis ___ • cardiac disease _____
   • diabetes ___ • cancer ___ • hypercholesterolemia ___
   • CVA___ • arteriosclerosis___ • others_____
4. Are there any genetic problems in your family?
   (cystic fibrosis, muscular dystrophy...)
   ❑ Yes:_____ ❑ No
5. Are there any congenital abnormalities in your family?
   (scoliosis, spina bifida, malformations...)
   ❑Yes:_____ ❑ No

Did you suffer or do you suffer from:

Yes	*No*	
❑	❑	Headaches (cephalgia, migraines)
❑	❑	Cholesterol / High or Low blood pressure
❑	❑	Fainting / Loss of consciousness
❑	❑	Cardiac problems (infarctus, palpitations, anginae, arythmea, heart murmur, valve troubles, etc.)
❑	❑	Circulatory problems (blocked artery, aneurism, swelling, CVA, phlebite, cold extremities)
❑	❑	Ocular or visual problems
❑	❑	Numbness
❑	❑	Loss of strength / Muscular cramps
❑	❑	Loss of appetite / Weight loss or gain
❑	❑	Liver or gallblader problems
❑	❑	Kidney problems
❑	❑	Pulmonary problems (asthma, tuberculosis...)
❑	❑	Digestive problems (ulcer, acidity, nausea, etc.)
❑	❑	Prostate problems
❑	❑	Urinary problems / Repetitive cystitis
❑	❑	Anemia / Hémophilia
❑	❑	Thyroid problems
❑	❑	Diabetes / Hypoglycemia
❑	❑	Bulimia / Anorexia
❑	❑	Constipation / Diarrhea
❑	❑	Depression / Nervousness / Anxiety / Tremors
❑	❑	Hyperventilation
❑	❑	Memory loss / Concentration difficulties
❑	❑	Allergies / Hayfever
❑	❑	Sinusitis / Frequent colds
❑	❑	Ear aches / Otitis / Ringing in the ears
❑	❑	Vertigo / Loss of balance/ Dizziness
❑	❑	Arthrosis / Arthritis
❑	❑	Blood in stools or urine
❑	❑	Skin disease
❑	❑	Chronic fatigue / Insomnia
❑	❑	Epilepsy / nervous tics
❑	❑	Excessive perspiration at night
❑	❑	Cancer / radiotherapy / chemotherapy
❑	❑	Venereal disease /HIV positive, AIDS

Declaration for all

Our team is happy to welcome you. You can be assured of our partnership towards better health. Today, a physical exam will be performed and may include X-rays, which could be taken on site. During your next visit, an explanation of the results will help you make an informed decision concerning your health.

At the present, I declare that all the information regarding my health status is complete and acurate and I authorize the physical examination and if necessary, X-rays to be performed on me (❑ on my child: _____). I understand that I am personally responsible for full payment of all charges for the services rendered. These charges are payable after each visit.

*Signature:*_____ *Date:*_____