CLINIQUE PASSION SANTÉ
CHIROPRATIQUE & MIEUX-ÊTRE

OPENING FILE

First Name: _____ Name: _____ Date of birth (D / M / Y): _____ / _____ / _____

Civil Status: Married ☐ Common-law partner ☐ Single ☐ Widowed ☐ Divorced ☐Other ☐ Gender: _____

Address: _____ City: _____ Postal code: _____

Phone # (residence): _____Cellphone: _____

Phone # (office): _____ E-mail: _____

What is the best way to reach you? Residential # ☐ Cellphone # ☐ Office # ☐ E-mail ☐ Text (SMS) ☐

Do you authorize the clinic to contact you by email? Yes ☐ No ☐

Do you allow the clinic to leave a message at the specified number to confirm an appointment? Yes ☐ No ☐

Do you authorize the clinic to leave a text message at the specified number to confirm an appointment? Yes ☐ No ☐

Occupation: _____ Currently off work? Yes ☐ No ☐

Who recommended you our clinic?

Other Professional: Name: _____ Clinic: _____

Spouse ☐ Friend ☐ Parent ☐ Colleague ☐ Name: _____

Advertisement ☐ Website ☐ Facebook ☐ Google ☐ Sign ☐ Other ☐ : _____

Name of your family doctor: _____

Last appointment: _____Date of the last medical examination: _____

Have you ever consulted a chiropractor? Yes ☐ No ☐

Who when?_____

Are you consulting for a problem related to an accident at work? Yes ☐ No ☐

Are you consulting for a problem related to a car accident? Yes ☐ No ☐

Person to join in case of emergency:

Name: _____ Name: _____ Phone: _____

Link with you: _____

I hereby authorize the chiropractor to perform the examinations necessary to open my file. Some patients may experience aches or mild worsening of symptoms following the examination. These symptoms are usually short-lived, but it is important to mention them to your chiropractor during your next visit.

Signature of patient or responsible person: _____

Date: _____

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1. What is the reason for your consultation?

   Please indicate your health problems in order of importance._____

   _____

   _____

   _____

2. How long have you been experiencing your main health problem? _____
3. How did this problem occur?

   Gradually ☐ Suddenly ☐

   Following an injury ☐ I do not know ☐
4. Is your problem present ...?

   100% of the time ☐ 50% of the time ☐

   75% of the time ☐ 25% of the time ☐

   Less than 25% of the time ☐
5. How does your problem evolve? It…

   Improves ☐ Worsens ☐ Do not change ☐
6. Is your problem more intense ...?

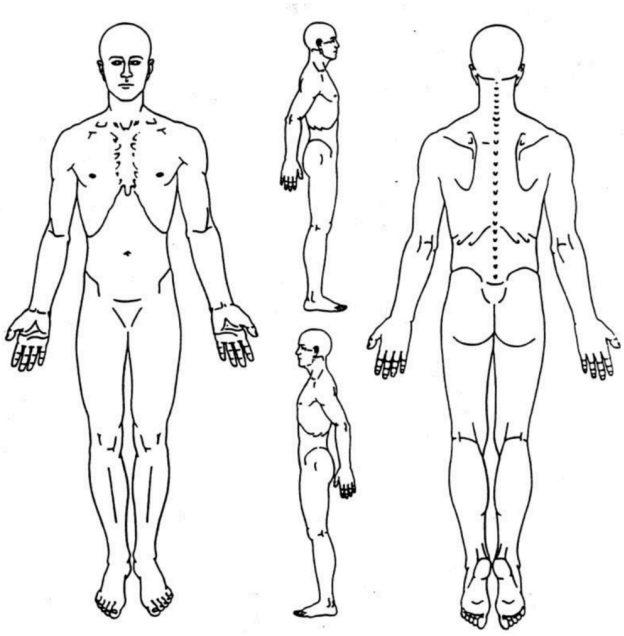
   At sunrise ☐, Day ☐, Evening ☐, Night ☐
7. Does your problem prevent you from ...?

   Work ☐, Sleep ☐, Lead your routine ☐
8. Have you consulted a health professional about this problem? No ☐ Chiropractor ☐ Doctor ☐

   Others ☐_____
9. Have you had a similar problem before?

   Yes ☐ No ☐

Please indicate on the diagram the exact locations of your pain (+++), your scars (***) and your fractures (XXX).



Check the box that corresponds to the severity of your main pain.

No pain — Extreme pain

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Date of your last exam:

	Less than 6 months	6-18 months	More than 18 months	Never
Chiropractic	☐	☐	☐	☐
Physical	☐	☐	☐	☐
Radiological	☐	☐	☐	☐
Blood tests	☐	☐	☐	☐
Urine tests	☐	☐	☐	☐

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FAMILY HISTORY:
1-Father: age _____ If deceased, cause_____
2-Mother: age _____ If deceased, cause_____
3-Do you have brothers and / or sisters? Yes □ No □
4-Do you have children? No □ Yes □ How many?___
5-Does anyone in your family have:
Heart problems □ Cancer □

Do you take medicine or natural products right now?
No □ If yes, complete the following section
Anti-depressant □_____
Anti-inflammatory □_____
Anti-coagulants □_____
Hormones □_____
For cholesterol □_____
Diabetes □_____
For blood pressure □_____
For the thyroid gland □_____
Anovulants □ _____
Other □_____

A-What is your position at work?
Standing □ Sitting □ In motion □

B- Do you wear ...? Heel pad □
Corrective insoles / orthotics □

C-Usually, do you sleep on ...?
The back □ The side □ The belly □

D-How many hours do you sleep per night? 4h and less □ 5-6h □ 7-8h □
9-10h □ 10-11h □ 12h and more □

E-Do you consume ...? If yes how much?
1. Tobacco / cigarette
No □ Yes □_____
2. Alcohol
No □ Yes □ _____
3. Coffee / tea
No □ Yes□_____
4. Vitamins and supplements
No □ Yes □
Which ones_____

F-Do you exercise?
Yes □ No □

DID YOU HAVE (∅) or DO YOU HAVE PROBLEMS WITH(□)
(Please tick the appropriate symbol)

1. ∅ □ Allergies
2.∅ □ Anguish
3.∅ □ Arthritis
4.∅ □ Bloating
5.∅ □ Low pressure
6.∅ □ Constipation
7.∅ □ Seizures
8.∅ □ Itching
9.∅ □ Depression
10.∅ □ Diabetes
11.∅ □ Diarrhea
12.∅ □ Bruising (easy bruises)
13.∅ □ Numbness
14.∅ □ Epilepsy
15.∅ □ Rashes (redness)
16.∅ □ Dizziness / vertigo
17.∅ □ Fainting
18.∅ □ Cold / moist extremities
19.∅ □ Fatigue
20.∅ □ Fracture
21.∅ □ Chills
22.∅ □ High pressure
23.∅ □ Hypoglycemia
24.∅ □ Urinary incontinence
25.∅ □ Insomnia
26.∅ □ Irritability
27.∅ □ Hereditary diseases
28.∅ □ Backache
29.∅ □ Headaches
30.∅ □ Meningitis
31.∅ □ Edema (swelling)
32.∅ □ Operation / Surgery
33.∅ □ Loss or weight gain
34.∅ □ Kidney stones
35.∅ □ Tremor
36.∅ □ Feet disorders
37.∅ □ Cardiac disorders
38.∅ □ Circulatory disorders
39.∅ □ Respiratory Disorders
40.∅ □ Vision problems
41.∅ □ Digestive Disorders
42.∅ □ Sexual Disorders (MTS)
43.∅ □ Hearing Disorders
44.∅ □ Hormonal disorders
45.∅ □ Psychological Disorders
46.∅ □ Renal disorders
47.∅ □ Varicose veins
48.∅ □ Nose bleeding
49.∅ □ Blood in the stool
50.∅ □ Blood in the urine
51.∅ □ Sinusitis
52.∅ □ Urinating Frequently
53.∅ □ Urinating at night
54.∅ □ Prostate disorders

<u>Section reserved for women</u>

55.∅ □ Absence of menstruation
56.∅ □ Abdominal cramps
57.∅ □ Abundant menstrual flow
58.∅ □ Painful menstruation
59.∅ □ Vaginal discharge
60.∅ □ Symptoms of menopause
61. Are you pregnant?
Yes □ No □

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Have you had: If yes, which ones?

Vaccines: No ☐ Yes ☐_____

Hospitalizations: No ☐ Yes ☐ _____

Accidents: No ☐ Yes ☐ _____

Dental procedures: Prostheses ☐ Implants ☐ Orthodontics ☐ Other ☐_____

With some care, where would you like to be in terms of your general health?

Obvious pain and discomfort	Some relief	Starting to improve	Symptom free	Feeling good	Enjoying care	Optimizing health	Optimal health

If your condition requires it, would you be willing to ...?

- ✓ Do exercise? Yes ☐ No ☐
- ✓ Take a supplement? Yes ☐ No ☐
- ✓ Follow some advice on lifestyle habits? Yes ☐ No ☐

I declare that I have completed this questionnaire to the best of my knowledge.

_____ _____

Signature of the patient or the person in charge

Date (DD/MM/AAAA)