

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: _____ Referred by: _____

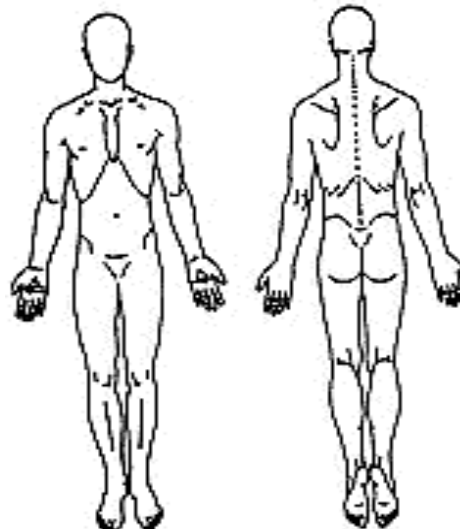
B

Complaint history

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

Indicate the exact location of your problems

Pain: XXXXX Numbness: ///// Tightness: -----



- ♦ Have you ever consulted any other professional 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 will be in better health?

C

Spinal health history

- 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
- What is your level of stress?**
 None Low Moderate High Extreme
- When was your last chiropractic exam?** _____
- What was the name of the chiropractor?** _____
- What type of care have you received?**
 Relief Corrective Preventive
- What approach or technique was used?**
 Adjustments Ultrasounds, electric stimulation Massage
- Have you had any X-Rays this year?**
 Yes (of which area? _____) No

D

Habits

- Physical activities? Yes: _____ No
- Computer/office work: ____h/day standing: ____h/day
 lifting weights: ____h/day repetitive movements: ____h/day
- Is your working area ergonomic? Yes No
- Diet : Poor Acceptable Good Excellent
- Tobacco: ____ / day Alcohol: ____ / week
 Tea, coffee: ____ / day Soft drink: ____ / day
- Sleep: Refreshing Non-refreshing
 Position: Stomach Back Side
 Adequate mattress : Yes No
 Orthopaedic pillow: Yes No

E

Section for women only

- Are you pregnant? Yes No Don't know
- Your periods are: Irregular Painfull Abundant
- Contraceptive method: _____
- Are you menopausal? Yes No
- Are you on hormone therapy? Yes No
- Have you noticed : A mass on your breast
 Abnormal vaginal secretions
- 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: _____
 - Suffering 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 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
- Earaches / 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 everybody

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 accurate 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: _____

The goal of the Clinique chiropratique Synergie is to restore and preserve health of those who appreciate its true value. Think about it, without any health capital, life loses all its interests!

You are in good hands!

Professional Fees

	Adults	Students	65 years and older		X-Rays	
Exam:	\$ 45	\$ 30	\$ 30	Cervical area:	\$ 30	Films 8X10: \$ 10
Reevaluation:	\$ 15	\$ 15	\$ 15	Thoracic area:	\$ 30	Films 10X12: \$ 15
Treatment:	\$ 40	\$ 30	\$ 35	Lumbar area:	\$ 40	Films 7X17: \$ 15
Cancelled appointment:	\$ 15			Extremity:	\$ 30	Films 14X17: \$ 25

(minimum 12 hours notice required to avoid charge)

An insurance form is given as requested to patients covered by an insurance plan.