CENTRES CHIROPRATIQUES

CENTRE CHIROPRATIQUE ROXBORO
10,400, boul. Gouin Ouest
Roxboro (Québec) H8Y 1W4
Tél. : 514 683-2157

CLINIQUE PARA-SANTÉ
559, Grand Boulevard
Île-Perrot (Québec) J7V 4X4
Tél. : 514 453-0001

PERSONAL FILE

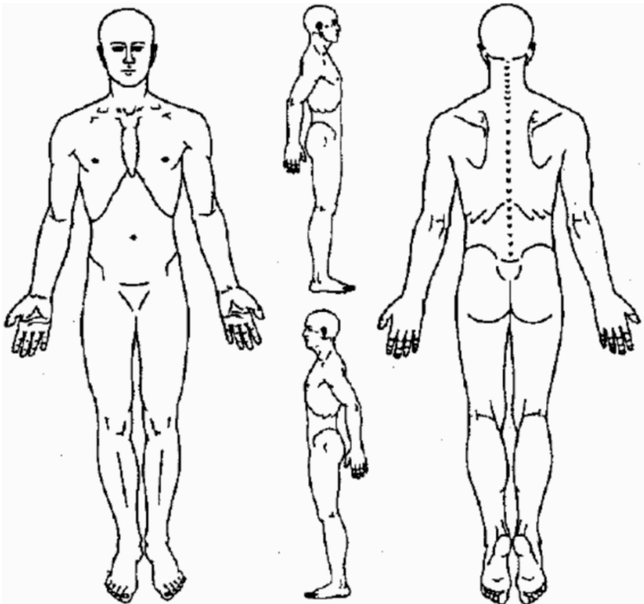
NAME : ______________________ DATE : ______________________

ADRESS: ______________________ ZIP CODE: ______________

PHONE (HOME) : ______________ # CELL : ______________ # WORK: ______________

E-MAIL : ______________________ REFERRED BY: ______________________

JOB DESCRIPTION : ______________________ DATE OF BIRTH: ______________________



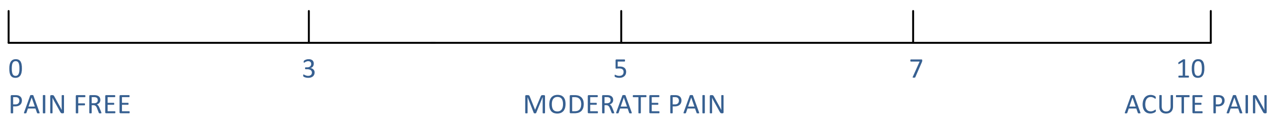
Please mark the exact location of your pain or tension, using the following symbols.

BURNING ////
PINS & NEEDLES XXXX
NUMBNESS ----
STABING 0000

Please describe your major problem:

____
____
____
____

Please mark on this line an (X) the level or intensity of pain that you are presently experiencing.



When did this pain (or problem) develop? ______________________

How did it start? ______________________

Is there anything you do that makes your condition worse? Better? ______________________

____

Please described ______________________

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Have you ever had this problem (or similar problem) before? ______________________________

Have you ever received any treatment for this condition? ______________________________

If yes, where, when and what were the results? ______________________________

Have you had any medical diagnosis of your complaint? ______________________________

Have you had any accidents or falls that might be related to your problem? ______________________________

Have you had previous chiropractic treatments? ______________________________

Date of treatment: ______________________________

Name of Doctor ______________________________

Résultat des traitements : ○ GOOD ○ FAIR ○ NUL

Leisure or sporting activities : ______________________________

CHECK THE SYMPTOMS THAT YOU HAVE NOTICED		SLEEPING HABITS
○ HEADACHE	○ FAINTING	**SLEEPING POSITION**
○ NECK PAIN	○ PINS & NEEDLES	○ BACK
○ LOW BACK PAIN	○ INSOMNIA	○ SIDE
○ FATIGUE	○ CONSTIPATION/DIARRHEA	○ BELLY
○ PULMONARY PROBLEMS	○ TENSION	**TYPE OF PILLOW**
○ CARDIAC PROBLEMS	○ MENSTRUAL PROBLEMS	○ ORTHOPEDIC
○ JOINT PAIN	○ RIGING IN THE EARS	○ MEMORY FOAM
○ DIZZINESS	○ OTHERS	○ ORDINARY

N.B. Radiograph (if taken) are part of your file and remain the property of the clinic. Fees are payable at the time of the visits.

SIGNATURE : ______________________________ DATE : ______________________________

(Please answer all of the questions)