



La Santé en Soi

Centre chiropratique holistique
714, rue King Est, suite 210
Sherbrooke (Qc) J1G 1C4
819 791-1337

Identification

Please complete with a pen

First Name: _____ Last Name: _____

Date of birth: day / month / year Age : _____

Address: _____

City: _____ Postal code: _____

Telephone: Home: _____ Work: _____

Cellular: _____ Other: _____

Can we leave a message at these numbers? _____

E-mail : _____

Occupation : _____

Marital status: single common law marriage married divorced/separated
 widow

Number of children: _____

How did you learn about La Santé en Soi?

Through a family member/ friend (name: _____)

Through a health professional (name: _____)

Mail publicity Yellow Pages

Other: _____

Have you ever had chiropractic treatment? yes no

Name of practitioner: _____

Reason for treatment: _____

When was your last adjustment? _____

Do you have a family doctor? yes no

Name of doctor: _____

Children/ Student (full time, 25 and under): First visit: \$40 Adjustments: \$30

Adult: First visit : \$50 Adjustments : \$40

Usually the first visit does not include an adjustment. X-rays not included.

I authorize La Santé en Soi to use, in a confidential and anonymous way, the information in my file for research or education. Yes No

Signature : _____ Date : _____



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Reason for consultation

Please write with a pen

Do not write anything in the gray squares

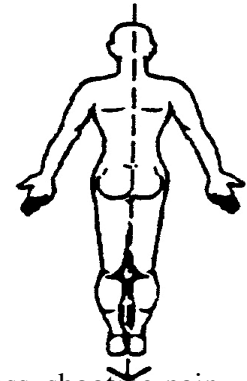
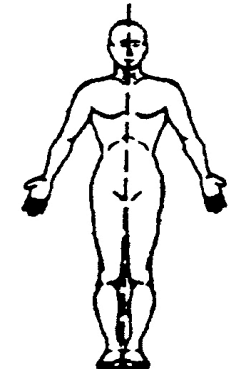
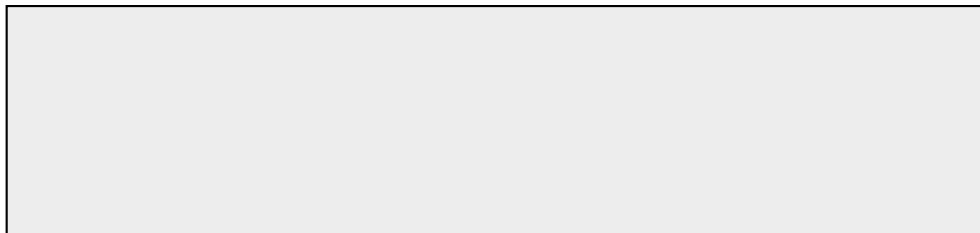
Why are you consulting La Santé en Soi? (Select one or many choices)

- Pain relief
- Prevention care
- Other: _____
- To address a problem
- Well-being care

Where is the pain? _____

When did it start? _____

How did it start? _____



What is the intensity of the pain? (Make a mark on the line)

No pain - 0 _____ 10 – Extreme pain

Which word best describes your pain? (for example : tension, burning, numbness, shooting pain, sharp pain, stabbing pain, etc.)

How often do you feel the pain? _____

How does your pain evolve during the course of the day? _____



What aggravates your pain (activity, posture, movements, etc)?

What relieves your pain (medication, heat/cold, posture, movement)?

Are there other symptoms that you feel are related to your pain?



Is it the first time that you have this type of pain?

Have you consulted another health professional regarding this problem?

Were you ever injured near the area of the pain?

Are there other health concerns you would like to share?

I declare that the information above is complete and accurate.

Signature: _____ Date : _____

Signature : _____ Date : _____



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Health History

First name: _____ Last name: _____

Personal history

Do you have any disease or health problems, diagnosed or not, present or past?

Do you take drugs (over the counter, prescription or contraception)?

If yes, which one(s) and why? : _____

Have you ever been hospitalized? (Year, duration and reason)

Have you ever had surgery? (Year, duration and reason)

Did you ever have an accident, a fall, or a major injury?

Family history :

Do your parents have a diagnosed disease?

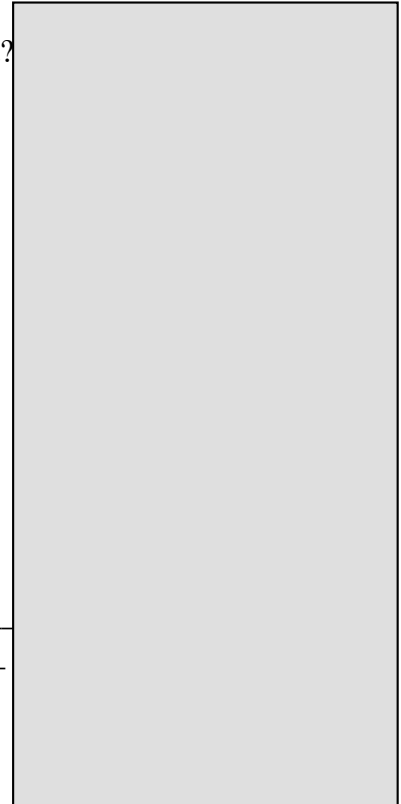
Father: _____

Mother _____

Do your grandparents have a diagnosed disease?

Paternal: _____

Maternal: _____



Body System overview Select the symptoms that you are experiencing:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Excessive thirst/ hunger | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Weight lost/gain | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Major fatigue | <input type="checkbox"/> Cold extremities | <input type="checkbox"/> Anemia | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Swelling / edema | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Anorexia/ bulimia |
| <input type="checkbox"/> Dizziness/ vertigo | <input type="checkbox"/> Pulmonary problems | <input type="checkbox"/> Pain during urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hereditary disease |
| <input type="checkbox"/> Anxiety/ depression | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> STD (present or passed) | <input type="checkbox"/> Congenital Anomaly |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Renal problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itching | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Psoriasis/Eczema | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Thyroids problems | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Nausea / vomiting | <input type="checkbox"/> Arthritis /Arthrosis | Are you pregnant? |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Blood in the stool | <input type="checkbox"/> Sciatica | <input type="checkbox"/> yes |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Tendonitis/ bursitis | <input type="checkbox"/> no |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Stiffness | <input type="checkbox"/> maybe |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness | |

Lifestyle

What is your average daily consumption of :

Fruits: _____ Vegetables: _____ Meat: _____ Poultry: _____ Fish: _____

Legumes: _____ Breads and pasta : _____

Water: _____ Soft drinks: _____ Coffee\tea: _____ Alcohol: _____

Meals at the restaurant: _____ / week Prepared meals: _____ / week

Do you smoke? yes no If yes, _____ pack by day or _____ pack by weeks

Do you use other drugs? yes no Substance and frequency: _____

Do you exercise? yes no How many times a week? _____

How many hours do you sleep? _____ In which position? _____

Do you wake up rested and refreshed? yes no

Stress

Our lifestyle makes us vulnerable to many types of stress in our day-to-day life. This stress may have an impact on our health.

To which physical stress are you exposed? (Select the ones that apply to you)

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Bad posture | <input type="checkbox"/> Accidents | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Repetitive movements | <input type="checkbox"/> Lack of physical activity | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Prolonged posture | <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Operations | |

To which chemical stress are you exposed?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Pollution | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tobacco / drugs |
| <input type="checkbox"/> Inadequate diet | <input type="checkbox"/> Soft drink | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Junk Food | <input type="checkbox"/> Energy drink | <input type="checkbox"/> Toxic products |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Dehydration | <input type="checkbox"/> Other: |

To which psychological stress are you exposed?

- | | | |
|---|--|--|
| <input type="checkbox"/> Stress at work | <input type="checkbox"/> Moving | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Stress at home | <input type="checkbox"/> Separation/divorce | <input type="checkbox"/> Psychological abuse |
| <input type="checkbox"/> Exams/ studies | <input type="checkbox"/> Change of employment | <input type="checkbox"/> Chronic disease |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Loss of employment | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lack of time | <input type="checkbox"/> Depression / Burn-out | |

Personal implications

What are you ready to do for your health?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Meet my chiropractor | <input type="checkbox"/> Drink water | <input type="checkbox"/> Modify my diet |
| <input type="checkbox"/> Do postural or other types of exercises | | <input type="checkbox"/> Do physical activity |
| <input type="checkbox"/> Modify my environment in an ergonomic way | | <input type="checkbox"/> Manage my stress |

I declare that the information above is complete and accurate.

Signature : _____ Date : _____