Your Health Profile

Name: _____ DOB: _____

Address: _____

Home phone: ( ) _____ Work phone: ( ) _____

Email Address: _____ Occupation: _____

Single ___ Married ___ Divorced ____ Widowed ____ / Does your insurance covers chiropractic care? Y / N

How did you hear about our services ?_____

For which reason(s) are your consulting our office? ___ Preventive check –up ___ Health issue; please list:
_____
_____

How long have you been experiencing this health problem? _____

This problem started : ___ gradually ___ suddenly ___ following a trauma ___ you don't know
Your problem is : ___ constant ___ comes and goes ___ getting worse ___ getting better
What aggravates your problem: _____
What makes it better: _____
Your problem affects : ___ work ___ sleep ___ daily routine
Have you seen a professional for that matter: ___ No ___ Yes , who: _____

Have you ever experienced issues with the following conditions: (Tick appropriate box)

	Past	**Present**
Feeling dizzy, Loss of balance		
Ocular problem		
Headaches, Migraine		
Ear ache		
Ringing in the ears		
Sinus problems, cold, allergies		
Heart problem		
Pulmonary problem		
Heartburn, Acid reflux		
Liver problem		
Kidney problem		
Diarhea, constipation		
Blood in urine or stool		
Circulatory problem		
Depression, anxiety		
Spinal or joint decay		
Sexually transmitted diseases		
Diabetes		
Thyroid problem		
Hypoglycaemia		
Skin problems		
Fatigue		
Pins & needles, numbness		
Epilepsy		

When was your last assessment done in regards to:

	< than 6 months	6 to 18 months	> than 18 months	Never
Chiropractic				
Physical				
X-rays				
Blood work				
Urine sample				

Lifestyle history

What is your working position : ___ standing ___ sitting ___ in motion
Do you wear: ___ orthotic insole ___ heel lift ___ lumbar belt ___ knee brace (with sports)
You normally sleep on : ___ back ___ side ___ stomach ___ combination of 3
How many hours of sleep do you get per night? ____ When you wake-up are you fully rested? ___

Do you smoke? ___ Since when ? _____ Amount /day: ___
Do you drink alcohol? ____ No ___ Socially ___ Regularly (How many drinks / week? ___)
Do you drink coffee? _____ No ____ Yes (How many cups / day? ___)
Do you take any natural supplements (Vitamins, minerals, homeopathy) ? ___ No ___ Yes
If yes please list: _____
_____
Do you exercise on a regular basis? ___ No ___ Yes
If yes please list: _____

Medical history

Which method was used at your birth? ___ Natural ___ C-section ___ Forceps / Suction cups
Have you been vaccinated ? ___ No ___ Yes
Have you been hospitalized? ___ No ___ Yes (If yes, please list)
Sickness: _____
Surgery: _____
Do you take any medication at the moment? ___ No ___ Yes
___ Anti-inflammatory ___ Pain killers ___ Muscle relaxant ___Diabetes ___ Blood pressure ___ Thyroid
Other(s): _____

Family history

Father's age: ____ If deceased (cause): _____
Mother's age: ____ If deceased (cause):_____
Do you have children? ____ Yes ____ No If yes, how many _____ Age: _____
Is there any degenerative diseases in your family? (Arthrosis, Arthritis, Heart disease, cancer, high cholesterol, diabetes, etc…) ____ Yes ____ No
Is there any genetic disease in your family? (Cystic fibrosis, down syndrome, etc…) ___ Yes ___ No

Women's health section

Are you pregnant ? ___ Yes ___ No ___ Maybe
Last menstrual period:_____ Are they regular? ___ Yes ___ No
Contraceptive method: _____
Are you in menopause? ___ Yes ___ No Are you on a hormonotherapy? ___ Yes ___ No
Have you noticed a lump on your breast? ___ Yes ___ No or abnormal vaginal secretions? ___ Yes ___ No

The statements made on this form are accurate to the best of my recollection and I agree to allow the chiropractor to examine me for further evaluation. **In reference to the article 3.07.01 of the chiropractic code of deontology, the original file and x-rays are the property of the chiropractor.** Photocopies can be made on demand and the fees are to be paid by the patient.

Signature: _____ Date: _____