St-Pierre Chiropratique
Optimisez votre potentiel de santé

Welcome!

YOUR HEALTH PROFILE

(Confidential)

Please, complete the entire survey. Your answers will allow us to adapt our chiropratic care depending on your health condition.

 # File : _____ **Date** : _____/_____ /_____

☐**Mr.** ☐**Mrs.** **Last name, First name** : _____ **Birth date :** _____/_____ /_____

Address : _____ **City** : _____ **Postal code** : _____

Tel. Home : _____ **Tel. work :** _____ **ext. :** _____ **Cell :** _____

Email : _____

Once a month, a newsletter on various aspects of health is sent by email.
Do you wish to receive it? ☐*Yes* ☐*No*

Civil status : ☐Married ☐Single ☐Law spouce ☐Widow (er)

Do you have children :☐Yes ☐No How many : _____ Age : _____

Occupation : _____ Working position, mostly : ☐Standing ☐Seatted

How did you hear about the clinic?

☐Reference of a person.
As we take the time to thank each patient who refers us, please write down the name of the person :
_____

Internet :
☐ Website St-Pierre Chiro ◯
☐ Facebook
☐ Internet review

Others :
☐ Outdoor display
☐ Other : _____

Wich of the following is the best way to confirm your appointments?
Telephone ☐ Email ☐ SMS ☐

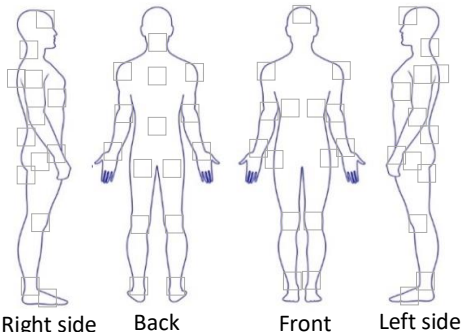
By consulting chiropractic, you wish :

☐Have no more pain (temporary releif)
☐Have no more pain and correct the problem
☐Prevent and optimize neuro spinal system

Have you ever received a chiropractic car before ?

☐ Yes, last visist was : _____
☐ No

<u>If you have any symptom, indicate the place (s) on the images below :</u>



Right side Back Front Left side

Specify if necessary :

_____
_____
_____
_____
_____

1. How did your problem happened?
☐ Fall ☐ Car accident ☐ Work accident ☐ Bad posture ☐ Sports injury
☐ Wrong move ☐ Other, specify : _____

2. It happened : ☐ Suddenly ☐ Gradually

3. Since when do you have this problem? : ___day(s) ___week(s) ___month(s) ___year(s)

4. On a scale from 1 to 10 (1 =low and 10 =high), where is your pain? : ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

5. So far, what did you do to help it?
☐ Painkiller/anti-inflammatory ☐ Ice ☐ heat ☐ Massage ☐ Other : _____

6. What do feel exactly? ☐ Pression ☐ Burn ☐ Blokcage ☐ Numbness ☐ Tension
☐ Fatigue ☐ Dizzy ☐ Other : _____

7. Does this problem interfere with your productivity or the quality of your work? ☐ Yes ☐ No

8. Are you obliged to stop working? ☐ Yes ☐ No

9. Does it affect your lifestyle? ☐ Yes ☐ No
…your hobbies? ☐ Yes ☐ No **… your rest?** ☐ Yes ☐ No

10. What are the moves that increase the pain? ☐ Bend over ☐ Lean back
☐ Neck movement ☐ Deep breath ☐ Cough/Sneeze ☐ Other : _____

11. Wich posture increase the pain? ☐ Long time sitting ☐ Long time standing ☐ Lying down

12. Have you had this problem before? ☐ Yes ☐ No

13. Have you been treated for this condition? ☐ Yes (By who?):_____ ☐ No

GENERAL HEALTH PROFILE

Check the symptom(s) you've had or the one(s) you have now :

Had before	Actual	GENERAL
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fatigue
☐	☐	Sinus
☐	☐	Concentration problem
☐	☐	Vertigo
☐	☐	Loss of balance
☐	☐	Irritability (decreasing patience)
☐	☐	Tinnitus (whistling in the ear)
☐	☐	Headache
☐	☐	Migraine
☐	☐	Ear infection

Had before	Actual	MUSCLE AND JOINT PAIN
☐	☐	Neck pain
☐	☐	Pain between shoulder blades
☐	☐	Pain in the middle back
☐	☐	Pain in the lower back
☐	☐	Sciatic
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Elbows
☐	☐	Wrists
☐	☐	Hips
☐	☐	Knees
☐	☐	Ankles
☐	☐	Numbness arms/hands
☐	☐	Numbness legs/feet

Had before	Actual	GASTROINTESTINAL TRACT
☐	☐	Slow digestion
☐	☐	Bloating
☐	☐	Gastric reflux
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Stomach ulcer
☐	☐	Stomach pain

Had before	Actual	CARDIOVASCULAR
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Chest pain
☐	☐	Cold extremeties

Had before	Actual	WOMAN ONLY
☐	☐	Menstrual pain
☐	☐	Abdominal cramps
☐	☐	Menstrual irregularity
☐	☐	Excessive menstruation
☐	☐	Absence of menstruation
☐	☐	Hot flashes
☐	☐	PMS

Had before	Actual	MAN ONLY
☐	☐	Irritation of the prostate
☐	☐	Erectile problem
☐	☐	Difficult urination
☐	☐	Frequetn urine (> 2 times/night)

For woman : Are you pregnent or are you planning to be soon? ☐ Yes ☐ No

Name all the medication you are taking at this moment (or give a copy of it) :

Name : _____ Dosage : _____

Name : _____ Dosage : _____

Name : _____ Dosage : _____

Specify the frequency of consumption of the following habits :

Habits	Number	Daily	Weekly	Monthly	Never
Alcohol					
Tobaco					
Coffee					
Sweets					
Physical exercises					
Hour of sleep/night					
Posture of sleep	☐ on your back ☐ on your stomach ☐ on your side				

Have you had one or more car accident in the past ? ☐ Yes, specify : _____ ☐ No

Have you had surgery in the past? ☐ Yes, specify : _____ ☐ No

Our goal is to provide the safest care possible. To be sure, it is important to perform a series of tests (radiography, thermography, applied kinesiology, neuroscience, etc.). I agree that the chiropractor conduct a full review and I declare that all information in this document is true

Signature : _____ **Date : _____**

Chiropractor's initials : _____

CONSENT TO CHIROPRACTIC TREATMENT

ORDRE DES CHIROPRATICIENS DU QUÉBEC

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor, to be familiar with the proposed treatment procedure and to make an informed decision about proceeding with treatment, in accordance with Section 43 of the *Code of ethics of chiropractors*.

Chiropractic treatment may include adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue (muscles and other supporting tissues) techniques, and other forms of therapy including, but not limited to, electrical or light therapy and prescribed exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for various issues affecting the neck, back and other areas of the body caused by nerve, muscle, joint and related tissue dysfunction. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve joint, muscle and nervous system function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** — Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** — Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** — Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** — While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** — Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** — Although current medical and scientific evidence does not indicate that chiropractic treatment causes artery damage or stroke, chiropractic treatment has, in rare cases, been associated with stroke. Such cases can, however, be explained by a previously damaged artery or by the fact that the patient was progressing toward a stroke when he or she consulted the chiropractor.

  Many activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck or a clot that already existed in the artery breaking off and travelling up to the brain.

  Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.
Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed my health status and the nature of the problem to be treated, the proposed treatment plan and the potential benefits and risks with the chiropractor.

I hereby declare that I have been informed of the alternatives to the proposed treatment.

I hereby declare that I have been given all the information and explanations needed to provide free and informed consent to the treatment proposed by the chiropractor.

I hereby declare that I have been informed that I can withdraw my consent at any time and that any significant changes to the proposed treatment plan will be subject to a separate consent.

Name (Please print)	Signature of patient (or legal guardian)	Patient's date of birth
Full name of chiropractor (Please print)	Signature of chiropractor	20 Date