# Personal File

☐ **Temporary Relief** ☐ **Corrective Care** ☐ **Chiropractor's Choice**

Date: _____

Surname_____ First Name: _____ Gender: _____

Address: _____Apartment: _____

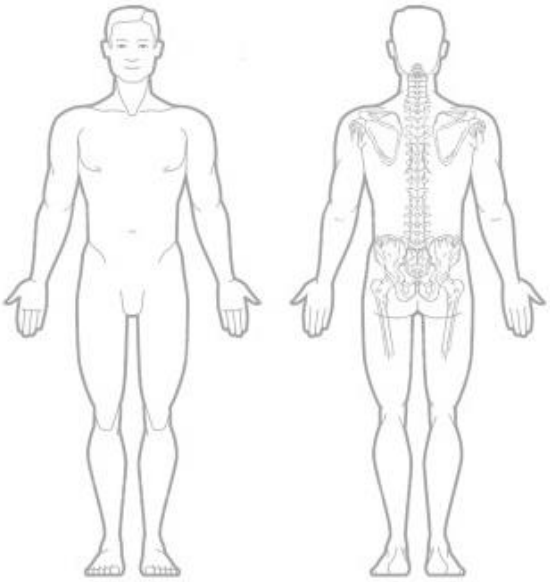
City: _____Postal Code: _____

Telephone: _____E-mail: _____

Date of Birth: _____ Age: _____ Occupation: _____

Height _____ Weight: _____ Referred by: _____

**Circle the area(s) where you feel pain (tenderness) and tension below.**



Main Problem

_____

Secondary problem(s)

_____

When did it begin?

_____

What is the cause? _____

_____

Have you had this problem before? _____

Do certain movements or positions aggravate the pain?

_____

_____

Other health problems and/or areas of pain?

_____

_____

Have you ever had an operation? _____

Have you ever been in a car accident? If yes, when? _____

Is your problem related to an accident, a fall, or another cause? _____

Are you taking any medication? Yes ☐ No ☐

Antidepressants ☐ Pain killer ☐ Muscle relaxant ☐ Anti-inflammatory ☐

Birth control ☐ Other: _____

Do you take vitamins? Yes No ☐ ☐

If yes, which ones? _____

Have you ever received chiropractic care? □ Yes □ No What were the results? □ Good □ Average □ No change

**Sleep** Average hours of sleep per night _____ Sleep position: back □ stomach □ side □

**Family history** (cardiac, diabetes, cancer, arthritis, thyroid, high cholesterol stroke, etc.)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

**Check the symptoms you have and the ones you have previously experienced.**

General

□ Night sweats □ Fatigue □ Weight gain □ Unexplained weight loss
□ Depression □ Cancer □ Fever □ Burn-out
□ Stress □ Loss of appetite □ Anxiety □ Mental health issues

Neurological

□ Dizziness/vertigo □ Memory loss □ Difficulty speaking □ Parkinson's
□ Fainting □ Headaches □ Migraine □ Difficulty walking
□ Stroke □ Alzheimer □ Weakness □ Tremors

Musculoskeletal

□ Arthritis □ Osteoarthritis □ Fracture □ Head injury
□ Neck pain □ Back pain □ Herniated disc □ Scoliosis

Endocrine

□ Thyroid gland problem □ Diabetes □ Other hormonal problems

ORL – ENT?

□ Vision problems □ Double vision □ Hearing loss □ Tinnitus
□ Earache □ Glaucoma □ Oral disorders □ Nose bleeds

Respiratory

□ Asthma □ Cough □ Difficulty breathing □ Chest pain

Other

□ Anemia □ Embolism □ Infarction □ Arrhythmia □ Diarrhea
□ High blood pressure □ Low blood pressure □ High cholesterol □ Allergies □ Constipation
□ Heartburn □ Ulcers □ Difficulty urinating □ Incontinence □ Gas

Male

□ Prostate □ Erectile dysfunction □ Testicular

Female

□ Hot flashes □ Missing periods □ Irregular menstruation □ Painful menstruation
□ Breast pain □ Menopause □ Infertility

Are you pregnant? _____ If yes, when is your due date? _____

I hereby authorize the chiropractor to perform the examinations he deems necessary to open my file. Some patients may experience aches or a mild worsening of symptoms after the examination. These symptoms are usually short-lived but it is important to mention them to the chiropractor during your next visit.

N.B. : Chiropractic care, even if it is covered by insurance, is payable at each visit. If your insurance company pays for all or part of your chiropractic care, we will accurately complete your claim to make sure that you receive the benefits to which you are entitled. X-rays remain the property of the clinic

Signature: _____