



457 route 105, unité 2
 Chelsea (QC)
 J9B 1L2
 (819) 827-4499
 www.chelseachiro.com

Form for the new Tall Ones

Date:

Before you begin, we would like to know to whom we owe an immense THANK YOU! for having referred you to us:

Please fill out all questions to the best of your knowledge. Everything will be reviewed with you later. This form needs to be filled with a pen, or on the computer. Just do not use a pencil.

Do not write in the white rectangles.

Thank you.

Personal information *(Please fill out with a pen)*

Last name:

First name:

Address:

Town/municipality/village:

Postal Code:

Phone Home:

Work:

Cell:

Is it ok to leave a message at these numbers?

Email:

Date of birth:

What is your occupation?

Where do you work?

Are you? single married with a partner divorced widowed

What is the name of your life partner?

What are the names of your children and their ages?

Present history

What is the main reason you are consulting us today?

Have you consulted another specialist for the same reason that brings you here? Yes No
If yes, who? When?

And what was the result?

Have you ever received chiropractic care before? Yes No

If yes, who was your chiropractor?

Date of last adjustment:

What did you like best about the care?

What did you like least about the care?

Secondary objectives

Are there any other reasons for seeking care that you would like to have addressed eventually?

Life history

Have you been a victim of birth trauma like

- Induction (provoked) C-section Other
 Peridural/epidural Forceps/ventouse

Have you received routine vaccinations? Yes / No Date of most recent vaccine: _____

Have you suffered from adverse reactions following vaccination? Yes No

Date of most recent bloodwork: _____

Do you suffer from imbalances like:

- Elevated cholesterol Diabetes Other chronic problem
 Hypertension Anemia

Have you ever...

- Had surgery? Yes / No If yes, when and why? _____
 Been a victim of falls, car collisions or other trauma? Yes / No
 o If yes, when and briefly describe:
 Broken any bones or lost consciousness? Yes / No
 o If yes, when and briefly describe:
 Been hospitalized? Yes / No If yes, when and why? _____

Family history

Are your mother and/or father in good health? Yes No

- o If No, briefly specify:

If you have any brothers or sisters, are they in good health? Yes No

- o If No, briefly specify:

If you have children, are they in good health? Yes No

- o If No, briefly specify:

Lifestyle

Do you take any medications (drugs), including the birth-control “pill”? Yes No

If Yes, which ones?

Since when and at what dosage?

Do you take any supplements, including vitamins? Yes No

If Yes, which ones?

Since when, and at what dosage?

Do you take any coffee, tea and/or soft drinks? Yes No

If Yes, how many?

Do you smoke cigarettes, marijuana and/or haschich? Yes No

If Yes, how many?

Do you drink alcohol? Yes No

If Yes, how much?

According to you, do you drink enough water? Yes No I do not know

How many glasses of water do you drink every day?

Do you exercise regularly? Yes No

If Yes, what do you do?

At what intensity? Low Moderate Intense

How many times per day or per week?

How many hours do you sleep at night?

Do you consider your sleep to be conducive to recuperation? Yes No

Do you wake up well rested in the morning? Yes No

Do you consider your diet to be healthy? Yes No

What food group do you eat most every day?

What food group do you eat least every day?

How many portions of cow’s milk do you drink every day?

Do you often eat...

- meals prepared and cooked at home meals at a restaurant
 meals that are prepared in advance by a store or a company?

Systems Review

Do you suffer from difficulties with...

- Your eyes – recurrent infections, cross-eyed, near-sightedness, far-sightedness...
- Your ears – ear infections, hearing difficulty, constantly hearing sounds...
- Your nose or your sinuses – congestion, frequent colds, sinusitis, allergies...
- Your mouth or your throat – abscesses, frequent sore throats...

- Your digestion – acid reflux, difficulty digesting certain foods, allergies...
- Your elimination – frequent diarrhea or constipation, difficulty/pain on urination...

- Your lungs and respiration – difficulty breathing, chronic bronchitis, COPD, asthma...
- Your heart – heart problems, feeling of palpitations, high or low blood pressure...

- Your nervous or vascular system – headaches, migraines, light-headedness, vertigo, loss of consciousness, trembling/shaking, numbness, memory loss...
- Your skin – frequent irritations, unusual pimple or plaques, rash...
- Your osseous and articular systems – articular pains...

- Your emotional health – towards work, home, school, finances, pregnancy, your role as a natural caregiver, loss of a loved one...
- Your psychological health – Depression, irritability, fatigue, nervousness...

- Your fertility – difficulties to conceive, miscarriages...
- Your genital system –
 - For women: menstrual pain, symptoms of menopause...
 - For men: erectile difficulties, lowering of libido...

What are your hobbies and/or your passions?

What relaxes you most?

Expectations

What are your expectations by coming here ?

Do you wish to receive care to ...

- Reduce symptoms/Patch, only to diminish pain
- To restore your health
- To maintain your health
- To increase your level of well-being (better-being)

Health and Quality of life are among the most precious things in this world – YOUR HEALTH AND YOUR FAMILY’S HEALTH. Chiropractic is there for You. The adjustments will help you to express your full potential of life. When you receive a chiropractic adjustment, the work has just begun. During the hours and days that follow your adjustment, your Innate Intelligence will continue to work by using the information received during the adjustment in order to make you better and so that your full healing power will be released. At the Maison Chiropratique Petits et Grands, we do not treat any condition or disease. We adjust people and the body decides, with its Innate Intelligence, what needs to be done, and what can still be done. Hence, we work in harmony with your inner wisdom. However, this process implies that you take back control of life and of your health, and that you accept to invest yourself in assisting “Dr You”.

I recognize that the given information is exact to the best of my knowledge and I consent to receive any necessary examinations.

Signature

Date