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## Form for the new Tall Ones

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**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, and send us the form back as soon as possible, in person, by fax or by email.

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:

Can we send emails to this address including a monthly private newsletter?  Yes  No

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?

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## **Present history**

Please tell us your story in your own words and pages if need be. If you are consulting us for wellness, tell us what else you are doing to improve this state. If you are consulting for a particular issue, tell us how you think this started, what has happened to you and what you have done since. You can add other sheets if necessary.

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?

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### Secondary objectives

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

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### Life history

As best as you know, how did your pregnancy go (when your mother was pregnant with you) and your birth?

Have you been a victim of birth trauma like

- Induction (provoked labour)       Forceps or ventouse
- Peridural/epidural/anesthesia       C-section       Other, specify:

Have you received routine vaccinations? Yes No

Have you suffered from adverse reactions following vaccination? Yes No

How was your health in general when you were...

- A child?
- A teenager?
  - o Were you very involved in sports?
    - Which sports in particular?

- If you are a woman, how was the beginning of your periods?
- An adult?

Date of the last bloodwork: \_\_\_\_\_

Do you suffer from imbalances like:

- Elevated cholesterol                       Diabetes    Other chronic problem, specify:
- 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
  - If yes, when and briefly describe:
- Broken any bones or lost consciousness?                      Yes    No
  - 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
  - If No, briefly specify:
  - Is there a history of heart or thyroid conditions or particular cancers in the family?

- If you have brothers, sisters and/or children, are they healthy?      Yes    No
  - 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  
 What position do you sleep in?  
 Is your mattress relatively firm?  
 How old is it?  
 What type of pillow do you have?  
 How old is it?
- Do you consider your diet to be healthy?      Yes    No  
 Are you vegetarian?  
 Do you eat fish and if so, how often?  
 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?
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## 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, eczema, psoriasis...
- 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...
  - Not too stressed?
- 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?

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## 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)

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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.

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**Signature**

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**Date**