Focus CHIROPRATIQUE

ADULT QUESTIONNAIRE

Name of patient : _____

Date of birth : _____ Sex : ☐ F ☐ M Age : _____

Are you seeking chiropractic care : ☐ for prevention ☐ for a particular health problem
Please describe : _____

If you are consulting for a specific problem :
Is this the first time you experienced that problem? ☐ yes ☐ no : *Last time it happened?*_____

Since when is the actual problem present? _____

Onset : ☐ sudden ☐ gradual ☐ I don't know
Duration : ☐ constant ☐ intermittent ☐ occasional

Have you seen any other health professional concerning that particular health problem? ☐ yes ☐ no
If so, which one(s): _____
Treatments : _____

Chiropractic history

Have you ever consulted another chiropractor? ☐ yes ☐ no
If so : when/how long/reason for consulting : _____
Name of chiropractor(s) : _____

Trauma history

Have you ever :

Fell from a certain height (at work, stairs, as a kid, etc.)	☐ yes	☐ no
Been in a motor vehicle accident?	☐ yes	☐ no
Fractured or dislocated any bone(s)?	☐ yes	☐ no
Had any sports injuries (sprain-strain, concussion...)?	☐ yes	☐ no
Sustained any other kind of trauma?	☐ yes	☐ no

If so, please describe : _____

Environment :

Are you : ☐ worker ☐ student ☐ at home ☐ retired ☐ other : _____
Describe your work/school environment : _____
Describe your occupations at home: _____

Your home environment is : ☐ very stressful ☐ stressful ☐ little stressful ☐ relaxing
Your work/school environment is : ☐ very stressful ☐ stressful ☐ little stressful ☐ relaxing ☐ N/A
Do you plan some leasure time in a typical week? ☐ yes ☐ no
If not, why? ☐ personal choice ☐ lack of time ☐ lack of interest ☐ other

Health history

Have you been diagnosed with any particular health condition by a health professional? ☐ yes ☐ no
*If so, please describe :*_____

Are you presently taking any drugs or medication (under prescription or over-the-counter), any natural products or nutritionnal supplements? ☐ yes ☐ no
If so, describe : _____

Have you ever had surgery? ☐ yes ☐ no
If so, describe : _____

Have you ever been hospitalized? ☐ yes ☐ no
If so, describe : _____

Please check, in the following conditions, the ones that describe your past or actual health condition:

Weight loss	Vertigo	Pneumonia	Thyroid problems	Urinary infection
Weight gain	Insomnia	Heart problems	Arthritis	Pain when urinating
High fever	Headaches	Reflux	Depression	Blood in urine
Night sweats	Nausea	Heartburn	Multiple sclerosis	Frequent urination
Cancer	Vomitting	Ulcers	Lupus	Psoriasis
Diabetes	Anemia	Difficult digestion	Numbness	Eczema
High blood pressure	Asthma	Diarrhea	Spasms	Other skin problem
Low blood pressure	Allergies	Constipation	Kidney infection	Deafness
Epilepsy	Sinusitis	Hepatitis	Kidney stones	Back or neck pain
Incontinence	Bronchitis	Alcoholism	Bladder infection	Arm or leg pain

Men : ☐ prostate problem ☐ erectile dysfunction ☐ testicular problem ☐ STD ☐ Other _____

Women : ☐ pregnant ☐ painful menstruations ☐ irregular menstruations ☐ no menstruations
☐ breast pain ☐ menopause ☐ hot flashes ☐ STD ☐ Other _____
☐ oral / intradermic contraceptives ☐ infertility hormonal treatment ☐ hormone replacement therapy

Family history : (known health conditions)

Please describe the health conditions that have been diagnosed in your following relatives :
*(heart problems, diabetes, cancer, arthritis, thyroid problems, high cholesterol, CVA, **others**)*

Mother : _____
Father : _____
Brothers/sisters : _____
Grandparents : _____
Others (uncle/aunt, cousins) : _____

Nutrition :

Are you concerned by any aspect of your nutritional habits? ☐ yes ☐ no
If so, please describe : _____

Fruits and vegetables :	☐ none	☐ some	☐ enough	☐ a lot	Daily : _____ portions
Meat :	☐ none	☐ some	☐ enough	☐ a lot	Daily : _____ portions
Cereals/whole grains :	☐ none	☐ some	☐ enough	☐ a lot	Daily : _____ portions
Dairy products :	☐ none	☐ some	☐ enough	☐ a lot	Daily : _____ portions

Softdrinks _____ per day Alcohol : _____ per day _____ per week
Water (glasses) _____ per day Coffee/Tea _____ per day
Fast-food _____ per week Restaurant _____ per week

Sleeping habits :

Hours of sleep per night : _____
Sleeping position : ☐ back ☐ stomach ☐ side (L or R)
Upon waking, you are : ☐ fully rested ☐ still tired ☐ unable to get up

Activities :

Sports : _____
Hobbies : _____
Hours dedicated to sports, per day or per week : _____
Hours spent watching television, per day or per week : _____
Hours spent on computer and/or video games (including work/study), per day or per week : _____
Are you : ☐ Smoker ☐ Former smoker ☐ Non-smoker

Do you have any other concern regarding your health? Are there any subjects you would like to receive additionnal information on regarding your general health ?

_____

_____