



# CHIROPRA TIQUE

## ALONZO DR. STÉPHANE CHILLIS

CHIROPRACTICIEN

**Phone Number : 819-246-4910**

Family Name :		Given Name :
Date of birth :	Day / Month / Year	Sex : M F
Address :		City :
Province :		Postal code :
Home phone :		Work phone :
Referred by :		Occupation :

Personal health insurance : \_\_\_\_\_ Family plan  Individual plan   
 Name of husband / spouse : \_\_\_\_\_ Number of children: \_\_\_\_\_ Children's age : \_\_\_ \_\_ \_\_

### CURRENT HEALTH CONDITION

List your chief complaints in order of severity :

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

Does the pain spread ? No  Yes  where ? \_\_\_\_\_

Do you have numbness ? No  Yes  where ? \_\_\_\_\_

Are there some movements or positions that make the pain worst ? No  Yes

Sitting  Standing  Leaning  Lying down  Other \_\_\_\_\_

Have you ever seen other doctors for this condition? No  Yes

If yes, who? \_\_\_\_\_

Type of treatment : \_\_\_\_\_ Any Results? \_\_\_\_\_

**Past chiropractic cares** No  Yes

Name of the chiropractor : \_\_\_\_\_ Date of the last treatment : \_\_\_\_\_

#### Drugs taken at this moment

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Analgesics        | <input type="checkbox"/> Anti-inflammatories               | <input type="checkbox"/> Hormones              |
| <input type="checkbox"/> Muscular relaxers | <input type="checkbox"/> High blood pressure tranquilizers | <input type="checkbox"/> Contraceptive pill    |
| <input type="checkbox"/> Anti-pain         | <input type="checkbox"/> Insuline                          | <input type="checkbox"/> Other/precise : _____ |

Sleeping position Back  Stomach  Sides

#### Accidents / Major fall /coma

- |   |            |            |
|---|------------|------------|
| <input type="checkbox"/> Car accident                 | Date _____ | Date _____ |
| <input type="checkbox"/> Major fall                   | Date _____ | Date _____ |
| <input type="checkbox"/> Cerebral concussion/<br>Coma | Date _____ | Date _____ |
| <input type="checkbox"/> Repetitive movements         | _____      |            |

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## PAST HEALTH HISTORY

Please check  any of the following diseases you have had

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*According to the Quebec Order of chiropractors; article. 3.07.01 of the code of ethics :*

- 1. The original patient's file, including x-rays, are the chiropractor's property.*
- 2. The law requires the chiropractor to keep all the original files, including x-rays for a period of 5 years.*

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*Patient's Signature/ curator*

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*Date*

- |  |                                       |                                     |                                 |
|--|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Thyroid      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Polio  |
| <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Alcoholism |                                 |

**MAJOR SURGERIES/ HOSPITALISATIONS**

- |                                       |                                       |  |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder  | <input type="checkbox"/> Back surgery          |
| <input type="checkbox"/> Tonsil       | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Other-Precise : _____ |
| <input type="checkbox"/> Fractures    |                                       |  |

**MUSCULAR -SKELETAL**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Joint pain/Stiffness/Swelling |
| <input type="checkbox"/> Arm pain             | <input type="checkbox"/> Sciatic nerve              | <input type="checkbox"/> Cold hands and feet           |
| <input type="checkbox"/> Neck pain            | <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Bursitis                      |
| <input type="checkbox"/> Difficulties to walk | <input type="checkbox"/> Stiffness in general       |  |

**NERVOUS SYSTEM**

- |                                    |                                     |                                    |   |
|------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Nervosity | <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Stress    | <input type="checkbox"/> Depression/confusion |
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Convulsion | <input type="checkbox"/> Paralysis |   |

**GENERAL**

- |                                    |   |                                    |  |
|------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Bad blood circulation |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Asthma    |  |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Hay fever |  |

**GASTRO-INTESTINAL**

- |  |   |                                      |  |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Chronic diarrhoea | <input type="checkbox"/> Haemorrhoids         | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Frequent nausea |
| <input type="checkbox"/> Liver problem     | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Ulcers      |  |

**GENTIAL-URINARY**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Painful/excessive urinary | <input type="checkbox"/> Incontinence |
|--|---------------------------------------|

**EYES/EAR/  
NOSE/THROAT**

- |                                 |   |
|---------------------------------|---|
| <input type="checkbox"/> Hum    | <input type="checkbox"/> Tinnitus           |
| <input type="checkbox"/> Otitis | <input type="checkbox"/> Hearing difficulty |

**CARDIO-VASCULAR**

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Phlebitis       | <input type="checkbox"/> Low blood pressure                |
| <input type="checkbox"/> Angina     | <input type="checkbox"/> Congested lungs | <input type="checkbox"/> Palpitations/ High blood pressure |
| <input type="checkbox"/> Infarct    | <input type="checkbox"/> Swelling ankle  | <input type="checkbox"/> Short breath                      |

**FAMILY HISTORY**

No Yes Father Mother Sister Brother Grand-parents Other \_\_\_\_\_

**WOMEN ONLY**

When was your last period? : \_\_\_\_\_

Are you pregnant? : Yes No Maybe

- |   |   |  |              |
|---|---|--|--------------|
| <input type="checkbox"/> P.M.S                  | <input type="checkbox"/> Breast pain      | <input type="checkbox"/> Bumps on breast | M.T.S. _____ |
| <input type="checkbox"/> Excessive bleeding     | <input type="checkbox"/> No menstrual     | <input type="checkbox"/> Heat flash      | Aids         |
| <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Vaginites       | Other _____  |

**MEN ONLY**

- |  |  |              |
|--|--|--------------|
| <input type="checkbox"/> Erective problems | <input type="checkbox"/> Prostate problems | M.T.S. _____ |
|--|--|--------------|