Option Santé Chiropratique St-Luc

Personal File

Referred by : ______________________________

Name : ______________________ Birth date : ______________

Address : ______________________ Appt. ________ Town : ______________

Postal Code : ______________________ Tel. (residential) : (   ) ______________

E-mail : ____

Employment : ______________________ Tel. (work) : (   ) ______________

Describe your symptoms by order of importance :

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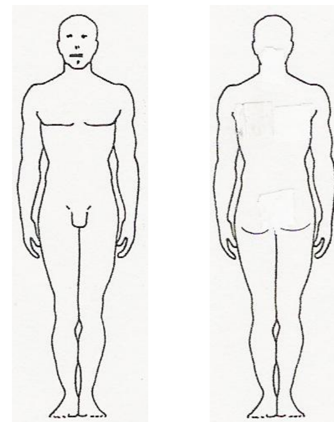
On this human diagram, circle the area where you feel discomfort.



Is your problem connected with a fall or accident?	YES ❑	NO ❑
Did you consult a medical Doctor for this problem?	YES ❑	NO ❑
Have you had any surgery during the past six months?	YES ❑	NO ❑
Does anyone in your family suffer from vertebral arthritis?	YES ❑	NO ❑
Have you ever had a car accident?	YES ❑	NO ❑
Is this your consultation with a chiropractor?	YES ❑	NO ❑

If not, consultation date : ______________________

Name of Chiropractor : ______________________

Treatment result : Good ❑ Fair ❑ Poor ❑

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Underline your symptoms present or past :

Headache	Diarrhoea	Intestinal gas	Hands numbness
Neck pain	Haemorrhoids	« Lump in the throat »	Numbness in feet
Rack pain	Palpitations	Stomach tightness	Breathlessness
Weakness	Dry skin	Joint swelling	Urinating problems
Asthma	Dizziness	Cold feet and hands	Fever
Bronchitis	Fainting	Memory loss	Blood in urine
Otitis	Tonsillitis	Epilepsy	Blood in stools
Hot-flashes	Bad digestion	Diabetes	
Numbness in hands	Insomnia	Allergies	
Irritability	Constipation		
Numbness in legs or buttocks			

Family health History

Does any member of your family suffer from :

Cancer	YES ❑	NO ❑	Others : ____________
Diabetes	YES ❑	NO ❑	____________
High blood pressure	YES ❑	NO ❑	____________
Arthritis	YES ❑	NO ❑	____________

Habits

What is your daily consummation of :

Cigarettes ________ / day Coffee ________ / day Alcohol ________ / day

Do you usually sleep on your stomach? YES ❑ NO ❑ Do you exercise regularly? YES ❑ NO ❑

Are you presently taking medication? YES ❑ NO ❑ Do you have a healthy diet? YES ❑ NO ❑

If so, which kind of medication? ____________________

Section reserved to women

Difficult menstrual cycle YES ❑ NO ❑ Breast masses YES ❑ NO ❑

Regular menstruation YES ❑ NO ❑ Menopause YES ❑ NO ❑

Are you pregnant? Do not Know❑ YES ❑ NO ❑ Last date of menstruation : ________

I declare that all the information written on this page true and I authorize Dr Alain Levaque to proceed with the chiropractic care I need.

Signature : ____________________ ____________________

Date

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