# INFORMATIONS / FILE OPENING

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Name : _____ Last name: : _____ Date of birth : (D/M/Y) _____

Civil status: Married ☐ Common-law partner ☐ Single ☐ Divorced ☐ Widow ☐ Other ☐ Sexe : _____

Adresse : _____ City : _____ Postal code: _____

Phone # home : _____ Phone # cell : _____

Phone # work: _____ Email : _____

What is the best way to reach you? Home phone ☐ Cell ☐ Work phone ☐ Email ☐

Do you authorize the clinic to communicate with you by email? Yes ☐ No ☐

Do you allow the clinic to leave a message at the specified number to confirm an appointment? Yes ☐ No ☐

Occupation : _____ Currently on sick leave? Yes ☐ No ☐

Do you have kids? Yes ☐ No ☐ How many? _____

Référé par : professional ☐ Name : _____ Clinic : _____

Partner ☐ Friend ☐ Parent ☐ Work collegue ☐ Name : _____

Publicity ☐ Web page ☐ Yellow Pages ☐ Facebook ☐ Google ☐ Other ☐ : _____

Name of your family doctor : _____

Last appointment : _____ Date of last medical examination : _____

Have you ever seen a chiropractor? Yes ☐ No ☐

Who? _____ When? _____

Do you consult for a problem related to a work accident (CSST)? Do Yes ☐ No ☐

you consult for a problem related to a car accident (SAAQ)? Yes ☐ No ☐

Agent Name: _____ File number : _____

Do you have care paid by the Veterans Affairs or IVAC program? Yes ☐ No ☐

Do you agree that we respond to requests from your insurer, Veterans Affairs Canada, IVAC, CSST or the SAAQ about the dates of your treatments and the amounts paid during these treatments? Yes ☐ No ☐

Person to contact in case of emergency :

Name : _____ Name : _____ Phone # : _____

Link to you: _____

I hereby authorize the chiropractor to carry out the examinations he deems necessary to open my file. Some patients may experience soreness or a slight worsening of symptoms following the examination. These symptoms are generally short-lived, but it is important to mention them to the chiropractor at your next visit.

Signature of patient or responsible person : _____

Date : _____

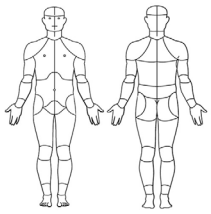
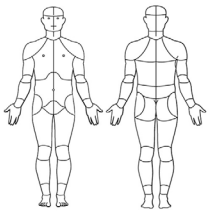
# HISTORY

D.C. : Martine Dionne N° de permis : _____

## PATIENT IDENTIFICATION

Name : _____ Last name : _____

Date : _____ Date of birth : _____ File number : _____

| | REASON : _____ | REASON: _____ |
|---|---|---|
| **REASON FOR CONSULTATION**<br><br>**Location of pain** | ☐ Head<br>☐ Cervical<br>☐ Thoracic<br>☐ Lombar<br>☐ Lower Limb<br>☐ Upper Limb<br>  <br>Notes : _____ | ☐ Head<br>☐ Cervical<br>☐ Thoracic<br>☐ Lombar<br>☐ Lower Limb<br>☐ Upper Limb<br>  <br>Notes : _____ |
| **Irradiation** | ☐ No ☐ Yes : _____ | ☐ No ☐ Yes : _____ |
| **Circumstance of occurence** | ☐ Suddenly ☐ Gradually<br>☐ Following an accident / Trauma<br>☐ Cause unknown<br>Specify: _____ Date : _____ | ☐ Suddenly ☐ Gradually<br>☐ Following an accident / Trauma<br>☐ Cause unknown<br>Specify: _____ Date : _____ |
| **Duration / Frequency** | ☐ Acute ☐ Sub acute ☐ Chronic ☐ Recurrent<br>_____ episodes in _____ ☐ Week ☐ Months ☐ Année<br>Duration : _____ Episodes : _____ | ☐ Acute ☐ Sub acute ☐ Chronic ☐ Recurrent<br>_____ episodes in _____ ☐ Week ☐ Month ☐ Year<br>Duration : _____ Episodes : _____ |
| **Progression** | ☐ Better ☐ Stable ☐ Worse ☐ Variable<br>_____ % on _____ ☐ Day ☐ Week ☐ Month<br>Specify : _____ | ☐ Better ☐ Stable ☐ Worse ☐ Variable<br>_____ % on _____ ☐ Day ☐ Week ☐ Month<br>Specify : _____ |
| **Pain**<br>Caracter / Intensity | ☐ Slenderness ☐ Stab ☐ Pinching<br>☐ Stretching ☐ Heat/Burn ☐ Tingling<br>☐ Numbness<br>☐ Other: _____ | ☐ Slenderness ☐ Stab ☐ Pinching<br>☐ Stretching ☐ Heat/Burn ☐ Tingling<br>☐ Numbness<br>☐ Other : _____ |
| **Aggravating + or mitigating factors -** | ☐ + ☐ - Ice ☐ + ☐ - Mouvement : _____<br>☐ + ☐ - Heat ☐ + ☐ - Medication : _____<br>☐ + ☐ - Rest ☐ + ☐ - _____ | ☐ + ☐ - Ice ☐ + ☐ - Mouvement : _____<br>☐ + ☐ - Heat ☐ + ☐ - Medication : _____<br>☐ + ☐ - Rest ☐ + ☐ - _____ |
| **Associated symptoms** | ☐ None ☐ _____ | ☐ None ☐ _____ |
| **Past history of current problem**<br><br>Previous treatment for this reason | Prev. episode ☐ Non ☐ Oui _____<br>☐ Treatment received for episode<br>Current: _____<br>_____ | Prev. episode ☐ Non ☐ Oui _____<br>☐ Treatment received for episode<br>Current: _____<br>_____ |

## PREVIOUS HISTORY OF TREATMENTS

**HEALTH PROFESSIONALS CONSULTED**

☐ Doctor ☐ Dentiste ☐ Optometrist
☐ Physiotherapist ☐ Other

_____

_____

## FAMILY MEDICAL HISTORY

Parent 1 : _____

Parent 2 : _____

Siblings : _____

Hereditary disease in the extended family: _____

**N = Normal AN = Abnormal**

| INITIALES | |
|---|---|

## ACCIDENTS, TRAUMA, SURGERIES AND HOSPITALIZATIONS

Accidents : _____ ☐ Yes ☐ No

Traumas : _____ ☐ Yes ☐ No

Surgeries : _____ ☐ Yes ☐ No

Hospitalizations : _____ ☐ Yes ☐ No

## LIFESTYLE HABITS

**SPORTS AND LEISURE**

**Level of sporting activity**

☐ VERY ACTIVE (+ 300 min./week moderate or + 150 min./week intense)

☐ ACTIVE (150 min./week moderate or 75-150 min./week intense)

☐ SEDENTARY (less 150 min./week . moderate and - 75 min./week intense.)

Main activities : _____

*Source : Organisation mondiale de la santé (2010). Recommandations mondiales en matière d'activité physique pour la santé.*

**SLEEP**

☐ Restorative sleep ☐ Insomnia

Number of hours of sleep per night : _____

**SLEEPING POSITION**

☐ Back ☐ Stomach ☐ Side ☐ Variable

☐ Pain that wakes you up at night : _____

**CHRONICIZATION FACTORS**

☐ feeling of poor health ☐ Smoking

☐ Depression sym ☐ Apprehension or catastrophizing

☐ Disproportionate reaction to the problem

☐ Kinesiophobia ☐ Total disability more than 12 months

☐ Alcohol or other addiction ☐ Low social network

☐ Family background ☐ Stressors

**OCCUPATION / WORK**

☐ School ☐ Work ☐ Full time ☐ Part time

☐ Constraining work postures: _____

Job satisfaction : / 10

☐ Recent work stoppage : _____

## MEDICATION ET SUPPLEMENTS

☐ List of medications in the file

☐ List in the DSQ

☐ Tylenol ☐ Aspirin ☐ NSAIDs / Muscle relaxants / Analgesics

☐ Opioids ☐ HTA ☐ Cholesterol ☐ Anxiolytics

☐ Anti-depressants ☐ Diabetes

☐ Injection medication ☐ Calcium / Vitamin D

☐ Over-the-counter medications ☐ Hormonal contraceptives

☐ Infiltration ☐ Anti coagulant / Anti platelet

Medication recently stopped: _____

☐ Other : _____

## RADIOGRAPHS, INVESTIGATIONS AND SPECIALIZED EXAMINATIONS

☐ X-ray (under 5 years) ☐ None

☐ Special examinations ☐ None

☐ Other investigations ☐ None

Upcoming investigation : _____

**OTHERS / ADDITIONS / COMMENTS**

## SYSTEMS REVIEW

| | | |
|---|---|---|
| Psychological | ☐ N ☐ AN | _____ |
| Neurological | ☐ N ☐ AN | _____ |
| Musculoskeletal | ☐ N ☐ AN | _____ |
| Endocrine | ☐ N ☐ AN | _____ |
| ENT | ☐ N ☐ AN | _____ |
| Respiratory | ☐ N ☐ AN | _____ |
| Cardiovascular | ☐ N ☐ AN | _____ |
| Gastrointestinal | ☐ N ☐ AN | _____ |
| Genitourinary | ☐ N ☐ AN | _____ |
| Allergies | ☐ N ☐ AN | _____ |

Other : _____

**CONSTITUTIONAL SYMPTOMS**

☐ Fever ☐ Fatigue ☐ Night pain

☐ Unexplained weight loss

☐ Night sweats ☐ Generalized discomfort

☐ Other: _____

**NMS RED FLAGS**

☐ Loss of genital/perianal sensation

☐ Urinary or fecal incontinence

☐ Urinary retention

☐ Morning release > 1 hour

☐ Cancer history

☐ Progressive neurological deficit

☐ Other : _____

**N = Normal AN = Abnormal**

| INITIALES | |
|---|---|