Centre chiropratique Dre Isabelle Ayers, DC
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# CONFIDENTIAL QUESTIONNAIRE

Date_____

Welcome to our Chiropractic Centre. Please fill in the following questionnaire as best you can. Should you need assistance, please advise us. This questionnaire is an important step towards a proper orientation of examination procedures and future recommendations. Thank you for your co-operation.

First name:_____ Last name:_____
Address:_____ City:_____ Postal Code:_____
Telephone number: at home_____ at the office_____
Cell phone number:_____ Internet address:_____
Date of birth: __ / __ / __ Age:_____ Sex: ❑ Male ❑ Female
Y M D
Marital status: ❑single ❑married ❑common law ❑spouse ❑separated ❑divorced ❑widow/widower
Number of children _____ and their respective ages_____
Insurance company:_____
Occupation:_____ Employer:_____
If you are retired, previous occupation:_____

• Who referred you to our centre? ❑ Doctor ❑ Friend ❑ Family member
Name _____ ❑ Telephone directory ❑ Sign
❑ Other, please specify:_____

• If the client is minor, please fill in the following authorization:
Parents' names: Mother_____ Phone number at work:_____
Father _____ Phone number at work:_____
I hereby consent to the examination of my child (and to eventual X rays), as well as to any chiropractic treatment that may be recommended.

•Name of your family physician_____ Address_____

•Have you been treated by a chiropractor in the past? ❑ Yes ❑ No

| Name of chiropractor | Date | Problem addressed |
|---|---|---|
| Name of chiropractor | Date | Problem addressed |

•Are you presently under the care of any other kind of health professional? ❑ No ❑ Yes
Physician, specialist, orthopaedist, neurologist, acupuncturist, physiotherapist, osteopath, massage therapist...

_____ Problem addressed_____
Name

_____ Problem addressed_____
Name

What is the main reason of your visit? _____

_____

_____

_____

If applicable, in your opinion, the problem arose on __ / __ / __ _____
Y M D

It began ❑ suddenly ❑ gradually ❑ following a specific event

_____

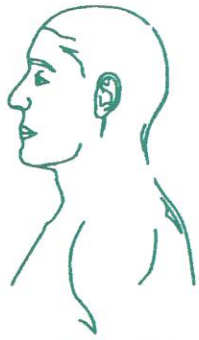
The problem is ❑ constant ❑ intermittent ❑ occasional ❑ cyclical
It occurs in episodes of ❑ minutes ❑ hours ❑ days ❑ months
Triggering factors: _____
Aggravating factors: _____
Relief, beneficial factors: _____
What effects does this problem have on your overall well being? _____

_____

Please indicate all other forms of treatment administered towards this problem *(include all medication).*

_____

Please indicate on the diagram all the problem areas.



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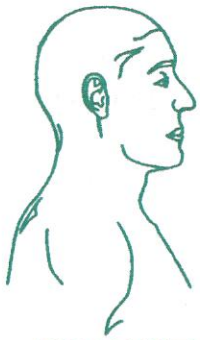

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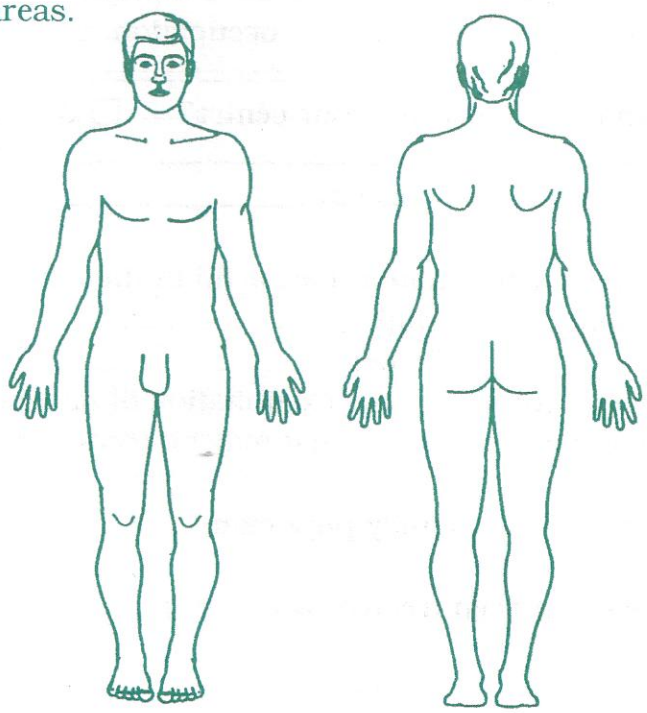

## WORK

• Is your case covered by the Workplace Safety and Insurance Board? ❑ No ❑ Yes
Your file number: _____ Name of the person in charge: _____

• Are you unemployed? ❑ No ❑ Yes
If so, since when? _____

• Are you currently on sick leave? ❑ No ❑ Yes
If so, duration of leave: _____

• Have you recently taken days off from work because of your health condition?
❑ No ❑ Yes
Please elaborate:

• Do you enjoy your work? ❑ Yes ❑ No

• Is the stress you are experiencing at work more than you can cope with at this time?
❑ No ❑ Yes

• You work ❑ sitting down ❑ standing up ❑ bent over ❑ squatting ❑ other
Please elaborate: _____

Do your tasks require physical strength? ❑ No ❑ Yes
Please elaborate: _____

## PHYSICAL STRESS

• Your birth:
Please indicate all significant information surrounding the story of your birth... Your mother's state of health, her drinking and smoking habits, the drugs and medication she took, the type of delivery she experienced (difficult, induced, caesarean, with the help of a vacuum extractor or forceps, with anesthesia, etc. _____

• From the date of your birth to this time, have you: (indicate the date and any relevant comment)
Undergone any operation/surgery? _____

Been hospitalized? _____

Had any accidents/experienced any traumatism, with or without broken bones (falls, head wounds, car accidents, sport injuries...)? _____

Have you ever lost consciousness or had convulsions? _____

Have you ever received radiotherapy or chemotherapy? ❑ No ❑ Yes

Do you ever intentionally "crack" the following? Your neck ❑ ❑ Your back
❑ No ❑ Yes

## LIFESTYLE

• In your opinion, is the quality of your sleep satisfactory? ❑ Yes ❑ No
Please elaborate: _____

_____

• Bedtime _____ Wake up time _____

• How do you sleep? On your back ❑ On your tummy ❑ On your side ❑

• Define your mattress: ❑ hard ❑ soft ❑ sunken ❑ comfortable ❑ uncomfortable ❑ waterbed

• Do you practice any of the following exercises? ❑ Meditation ❑ Relaxation ❑ Breathing

_____

• Do you engage in any physical activity? ❑ Yes ❑ No What type and how often? _____

_____

• Are you satisfied with your present weight? ❑ Yes ❑ No Present weight: _____ lbs/kgs.

• Have you recently gained or lost more than 5 pounds (2,2 kilos)? ❑ Yes ❑ No
Please elaborate: _____

_____

_____

• How frequent are your bowel movements? _____ Times per day _____ Times per week

• Define your stools: ❑ hard ❑ loose ❑ normal

• Do you wear any of the following? Foot orthosis ❑ Orthopaedic heels ❑ Eyeglasses ❑
Contact lenses ❑ Dentures ❑ Partial ❑ Hearing aid ❑ Pace maker ❑

• Have you ever experienced emotional or mental distress? ❑ No ❑ Yes
Please elaborate: _____

• What do you do in your spare time, what are your hobbies? _____

_____

• What do you find stressful? _____

_____

• Do you eat out on a regular basis? ❑ No ❑ Yes What kind of restaurants do you patronize?

_____

• Were you vaccinated as a child? ❑ No ❑ Yes

• Have you ever experienced a post-vaccination reaction? ❑ No ❑ Yes
Please elaborate: _____

• Have you been vaccinated recently (flu, hepatitis B, meningitis, any trip related disease...)? ❑ No ❑ Yes
What type of vaccine was it? _____

Were you often ill as a child? ❑ No ❑ Yes
Please explain: _____

## CHEMICAL STRESS

• List all the prescription and over the counter drugs you take (name and dosage):

heart
blood pressure
sleep
antidepressant
migraine
analgesics
birth control pill
muscle relaxant
anti inflammatory
bronchodilator
pump
arthritis
thyroid
hormones
antibiotics
antacid
ulcer
laxative
diabetes
lithium
chemotherapy
recreational drugs

• Indicate any other product, vitamin, homeopathic preparation, etc. _____

• In the past, have you made frequent use of some drug or product not mentioned above?
❑ No ❑ Yes If so, name it. _____

• In the following list of foods, check off the ones that you eat or drink and, if applicable, indicate how much and how often.

Frozen meals ❑ _____
Restaurant meals ❑ _____
Canned or powdered soups ❑ _____
Canned or powdered sauces ❑ _____
French fries ❑ _____
Fast food, fried foods ❑ _____
Pizza ❑ _____
Chips ❑ _____
Deli meats ❑ _____
Cheese ❑ _____
Glass of milk ❑ _____
Yoghurt ❑ _____
Ice cream ❑ _____
Margarine ❑ _____
Chocolate ❑ _____
White sugar ❑ _____
Candy ❑ _____
Desserts, pastries ❑ _____
Artificial sweeteners ❑ _____
Sugarless gum ❑ _____
Soft drinks
regular ❑ diet ❑ _____

Coffee ❑ _____
Tea ❑ _____
Herbal tea ❑ _____
Water ❑ tap, spring, distilled _____
Beef ❑ _____
Chicken ❑ _____
Fish ❑ _____
Pork ❑ _____
Potato ❑ _____
Pasta ❑ _____
White bread ❑ _____
Other type of bread ❑ _____
Fresh fruit ❑ _____
Canned foods ❑ _____
Raw vegetables ❑ _____
Cooked vegetables ❑ _____
Tofu ❑ _____
Soya ❑ _____
Nuts ❑ _____
Cold pressed oil ❑ _____

Do you drink alcoholic beverages? ❑ No ❑ Yes What do you drink? _____
How much? _____

- Did you ever smoke? ❑ No ❑ Yes For how many years?_____ How much?_____
  When did you quit?_____
- Do you smoke (cigarettes, cigars or the pipe)? ❑ No ❑ Yes When did you start?_____
  How much do you smoke?_____
- Are you regularly exposed to chemicals at work, at home or during your leisure time?

_____

_____

## SECTION TO BE FILLED BY MEN ONLY

- Does your urine appear to be of normal colour and odour? ❑ No ❑ Yes
- Do you get up at night to urinate? ❑ No ❑ Yes Number of times: _____
- Do you have trouble urinating? ❑ No ❑ Yes Please elaborate: _____
- Do you have any sexual difficulty? ❑ No ❑ Yes Please elaborate: _____
- Is venereal disease something you are presently suffering from or have suffered from in the past? ❑ No ❑ Yes If so, which type? _____
- Do you experience fertility problems? ❑ No ❑ Yes _____
- Do you have a prostate problem? ❑ No ❑ Yes _____

## SECTION TO BE FILLED BY WOMEN ONLY

- Are you pregnant? ❑ No ❑ Yes If so, how far along are you? _____
- Do you use any birth control method? ❑ No ❑ Yes Which type? _____
- Date of the first day of your last menses: _____
- Is your menstrual cycle regular? ❑ No ❑ Yes How long is it? _____
- Is the blood flow heavy? ❑ No ❑ Yes _____

Number of deliveries: _____ Miscarriages: _____

Define your deliveries: ❑ natural ❑ with epidural analgesia ❑ by caesarean

- Have you ever noticed any lumps in your breasts? ❑ No ❑ Yes _____

_____

- Have you ever had any of the following?

Ovarian, uterine or vaginal cyst ❑ No ❑ Yes _____

Fibroma ❑ No ❑ Yes _____

Curettage ❑ No ❑ Yes _____

Biopsy ❑ No ❑ Yes _____

Mammography ❑ No ❑ Yes _____

Positive Pap test ❑ No ❑ Yes _____

Venereal disease ❑ No ❑ Yes Which one? _____

_____

- When was your last gynecological examination? _____

• About 2 weeks prior to your menses, do you experience the following symptoms?

Weight gain ❑
Depression ❑
Irritability, mood swing ❑
Swelling, fluid retention ❑
Nausea and/or vomiting ❑
Suicidal feeling ❑
Anxiety ❑
Pain and cramping in legs ❑
Asthma attack ❑
Headaches and migraines ❑
Difficulty to concentrate ❑
Breast tenderness ❑
Low back pain ❑
Other ❑ _____

• During your period, do you experience the following symptoms?

Pain in the abdomen ❑
Low back pain ❑
Increased urinating ❑
Diarrhea ❑
Headaches and migraines ❑
Nausea and/or vomiting ❑
Need to stay in bed for a day or two ❑
Insomnia ❑
Increased taste for sugar or salt ❑

Are you experiencing sexual dysfunction? ❑ No ❑ Yes If so, please explain: _____

• Have you entered or gone through menopause? ❑ No ❑ Yes Your age at that time: _____

Do you suffer from symptoms associated with menopause? ❑ No ❑ Yes Such as? _____

• For each one of the following body parts, please indicate any dysfunction, discomfort, pain... Please elaborate as to the nature, frequency, intensity and length of time of whatever is ailing you.

❑ Head (headaches, migraines) _____ Larynx ❑
❑ Scalp _____ Cough ❑
❑ Face _____ Thyroid ❑
❑ Vision _____ Rib cage ❑
❑ Eyes _____ Chest ❑
❑ Hearing ability _____ Lungs ❑
❑ Ears _____ Asthma ❑
❑ Dizziness ❑ Balance _____ Bronchial tubes ❑
❑ nose _____ Respiration ❑
❑ Smell _____ Frequent colds ❑
❑ Sinus _____ Heart palpitation ❑
❑ Taste _____ Blood pressure ❑
❑ Gums _____ High cholesterol ❑
❑ Teeth _____ Cerebrovascular stroke (CVA) ❑
❑ Mouth _____
❑ Jaws _____ Bloodstream disorder ❑
❑ Tonsils _____ Varicose veins ❑
❑ Throat _____ Stomach ❑

- ❑ Ulcer
- ❑ Acid reflux
- ❑ Digestion
- ❑ Bloating
- ❑ Nausea
- ❑ Liver
- ❑ Gallbladder
- ❑ Spleen
- ❑ Pancreas
- ❑ Intestines
- ❑ Diverticula
- ❑ Hemorroids
- ❑ Rectum
- ❑ Gas, flatulence
- ❑ Bladder
- ❑ Kidneys
- ❑ Abdomen
- ❑ Hernia
- ❑ Ovaries / testicles
- ❑ Uterus / prostate
- ❑ Neck
- ❑ Upper back
- ❑ Middle back
- ❑ Low back
- ❑ Pelvis
- ❑ Tail bone
- ❑ Leg
- ❑ Knee
- ❑ Ankle
- ❑ Foot

- ❑ Toes
- ❑ Shoulder
- ❑ Arm
- ❑ Elbow
- ❑ Wrist
- ❑ Hand
- ❑ Fingers
- ❑ Allergies
- ❑ Psoriasis
- ❑ Eczema
- ❑ Acne
- ❑ Dry skin
- ❑ Itching
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ Insomnia
- ❑ Fatigue
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Tumor
- ❑ Epilepsy
- ❑ Burn out
- ❑ Anxiety
- ❑ Nervousness
- ❑ Mental disorders
- ❑ Emotional disorders
- ❑ Other:

Family history:

## CLIENT'S DECLARATION

I declare that all the information given is complete and correct. I hereby authorize the Doctor of Chiropractic to perform the physical and radiological examinations and any necessary procedure to help me maintain or improve my health.

Date

Client's (or legal representative's) signature