INFORMATION/NEW FILE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

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

Civil status: Married ☐ Living common-law ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐ Sex: _____

Address: _____ City: _____ Postal code: _____

Home phone: _____ Cell phone: _____

Office phone: _____ E-mail: _____

What is the best way to reach you? Home phone ☐ Cell phone ☐ Office phone ☐ E-mail ☐

Do you authorize the clinic to contact you by e-mail? Yes ☐ No ☐

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

Occupation: _____ Are you currently on leave from work? Yes ☐ No ☐

Do you have any children? Yes ☐ No ☐ If so, how many? _____

Referred by: Other professional ☐ Name: _____ Clinic: _____

Spouse ☐ Friend ☐ Parent ☐ Co-worker ☐ Name: _____

Advertisement ☐ Website ☐ Yellow Pages ☐ Facebook ☐ Google ☐ Other ☐ : _____

Name of your family physician: _____

Last appointment: _____ Date of last medical examination: _____

Have you ever consulted a chiropractor? Yes ☐ No ☐

Who? _____ When? _____

Are you consulting for a problem related to an occupational accident (CNESST)? Yes ☐ No ☐

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

Name of representative: _____ File number: _____

Is your treatment covered by a Veterans Program or IVAC? Yes ☐ No ☐

Do you agree to have us reply to requests made by your insurer, Veterans Affairs Canada, IVAC, the CNESST or the SAAQ regarding your treatment dates and the amounts paid for those treatments? Yes ☐ No ☐

Person to contact in case of emergency:

Last name: _____ First name: _____ Telephone number: _____

Relationship: _____

I hereby authorize the chiropractor to conduct the examinations that he or she deems necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally do not last long, it is important to mention them to the chiropractor at your next appointment.

Patient's signature or signature of person responsible: _____

Date : _____

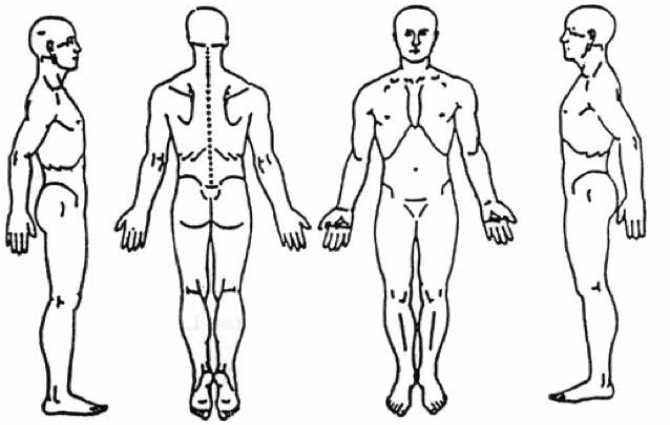
ADMISSION QUESTIONNAIRE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Last name: _____ First name: _____

Date of birth (M/D/Y): ____ / ____ / ____ **Are you consulting**: for preventive reasons ☐ for a particular problem ☐

Please indicate the painful points on the drawing, if applicable.



What is your main reason for consulting?

_____

_____

_____

What other problems do you have, in order of importance?

_____

_____

_____

_____

- How long have you had your main problem? _____
- How intense is your pain? Little pain 1 2 3 4 5 6 7 8 9 10 Extreme pain
- How many days a week does this problem affect you? 1 2 3 4 5 6 7
- How did this problem start? Gradually ☐ Suddenly ☐ Following an accident ☐ I don't know ☐
- Is your problem more intense... when you get up in the morning? ☐ during the day? ☐ in the evening? ☐ at night? ☐

Have you consulted anyone else about this condition? Yes ☐ No ☐

Who? _____ *When?* _____

Have you ever had surgery? Yes ☐ No ☐ **Have you ever been hospitalized?** Yes ☐ No ☐

If so, please specify. _____

_____

_____

Have you been treated for other health problems in the past year? Yes ☐ No ☐

Description _____

_____

History of trauma:

Have you ever: fallen (at work, during childhood, at home, etc.)? Yes ☐ No ☐ _____

been involved in a car/motorcycle/other accident? Yes ☐ No ☐ _____

had a fracture or a dislocation? Yes ☐ No ☐ _____

had a sports injury (e.g. sprain, concussion)? Yes ☐ No ☐ _____

been the victim of another accident? Yes ☐ No ☐ _____

Are you currently taking any medication (prescription or OTC), natural products or nutritional supplements?

Yes ☐ No ☐ If so, which ones? : _____

Anti-inflammatories ☐ Muscle relaxants ☐ Analgesics ☐ Blood pressure medication ☐ Cholesterol medication ☐ Oral contraceptives ☐

Thyroid medication ☐ Diabetes medication ☐ Antidepressants ☐ Anti-anxiety medication ☐ Other: _____

Date of your last: physical examination _____ blood test _____ urine test _____

Are you a: smoker? ☐ ex-smoker? ☐ non-smoker? ☐

Do you suffer from or have you ever suffered from:

General

☐ Night sweats	☐ Fatigue	☐ Weight gain	☐ Unexplained weight loss
☐ Depression	☐ Cancer	☐ Fever	☐ Burnout
☐ Stress	☐ Loss of appetite	☐ Anxiety	☐ Other psychological problems

Neurological

☐ Dizziness/vertigo	☐ Memory loss	☐ Difficulty speaking	☐ Parkinson's disease
☐ Fainting	☐ Headaches	☐ Migraines	☐ Difficulty walking
☐ Stroke	☐ Alzheimer's disease	☐ Weakness	☐ Tremors

Musculoskeletal

☐ Arthritis	☐ Arthrosis	☐ Fracture	☐ Head injury
☐ Neck injury	☐ Back injury	☐ Disc herniation	☐ Scoliosis

Endocrine

☐ Hyperthyroidism	☐ Hypothyroidism	☐ Diabetes	☐ Another hormonal problem

ENT

☐ Vision trouble	☐ Double vision	☐ Loss of hearing	☐ Tinnitus
☐ Ear pain	☐ Glaucoma	☐ Mouth problems	☐ Nosebleeds

Respiratory

☐ Asthma	☐ Cough	☐ Respiratory problems	☐ Chest pain

Other

☐ Anemia	☐ Embolism	☐ Heart attack	☐ Arrhythmia
☐ High blood pressure	☐ Low blood pressure	☐ High cholesterol	☐ Allergies: _____
☐ Heartburn	☐ Ulcers	☐ Difficulty urinating	☐ Incontinence

Men

☐ Prostate problems	☐ Erectile dysfunction	☐ Testicular problems	☐ STBI (STI)

Women

☐ Hot flashes	☐ Absent menstruation	☐ Irregular menstruation	☐ Painful menstruation
☐ Sore breasts	☐ Menopause	☐ STBI (STI)	☐ Infertility

Are you pregnant? Yes ☐ No ☐ If so, when are you expecting? _____

Sleep: Average number of hours of sleep per night _____ Sleep position: back ☐ stomach ☐ side (L or R) ☐

When you wake up, are you: well rested? ☐ tired? ☐ unable to get up? ☐

Activities (sports/recreation): _____

Stress: on a scale of 0 to 10, how would you rate your stress level? 0 1 2 3 4 5 6 7 8 9 10

Diet: Are you concerned about your diet? Yes ☐ No ☐ If so, please specify:

_____

Do you have other health concerns? Yes ☐ No ☐ If so, please specify:

_____

Family history: (e.g. cardiac problems, diabetes, cancer, arthritis, thyroid problems, high cholesterol, stroke)

Mother : _____

Father: _____

Brothers/sisters: _____

Grandparents: _____

I declare that I have filled out this questionnaire to the best of my knowledge.

Patient's signature or signature of person responsible _____ Date: _____

CONSENT TO CHIROPRACTIC TREATMENT

ORDRE DES CHIROPRATICIENS DU QUÉBEC

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor, to be familiar with the proposed treatment procedure and to make an informed decision about proceeding with treatment, in accordance with Section 43 of the *Code of ethics of chiropractors*.

Chiropractic treatment may include adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue (muscles and other supporting tissues) techniques, and other forms of therapy including, but not limited to, electrical or light therapy and prescribed exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for various issues affecting the neck, back and other areas of the body caused by nerve, muscle, joint and related tissue dysfunction. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve joint, muscle and nervous system function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** — Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** — Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** — Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** — While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** — Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** — Although current medical and scientific evidence does not indicate that chiropractic treatment causes artery damage or stroke, chiropractic treatment has, in rare cases, been associated with stroke. Such cases can, however, be explained by a previously damaged artery or by the fact that the patient was progressing toward a stroke when he or she consulted the chiropractor.

  Many activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck or a clot that already existed in the artery breaking off and travelling up to the brain.

  Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.
Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed my health status and the nature of the problem to be treated, the proposed treatment plan and the potential benefits and risks with the chiropractor.

I hereby declare that I have been informed of the alternatives to the proposed treatment.

I hereby declare that I have been given all the information and explanations needed to provide free and informed consent to the treatment proposed by the chiropractor.

I hereby declare that I have been informed that I can withdraw my consent at any time and that any significant changes to the proposed treatment plan will be subject to a separate consent.

Name (Please print)	Signature of patient (or legal guardian)	Patient's date of birth
Full name of chiropractor (Please print)	Signature of chiropractor	20 Date