CHIROPRATIQUE ALONZO
DR. STÉPHANE CHILLIS
CHIROPRATICIEN

Phone Number : 819-246-4910

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

Name of husband / spouse :_____ Number of children: _____ Children's age :___ ___ ___
Personal health insurance : _____ Family plan ☐ Individual plan ☐

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

☐ Analgesics ☐ Anti-inflammatories ☐ Hormones
☐ Muscular relaxers ☐ High blood pressure tranquilizers ☐ Contraceptive pill
☐ Anti-pain ☐ Insuline ☐ Other/precise :_____

Sleeping position Back ☐ Stomach ☐ Sides ☐

Accidents / Major fall /coma

☐ Car accident Date_____ Date_____
☐ Major fall Date_____ Date_____
☐ Cerebral concussion/ Coma Date_____ Date_____
☐ Repetitive movements _____

PAST HEALTH HISTORY

Please check ☑ any of the following diseases you have had

☐ Pneumonia	☐ Thyroid	☐ Diabetes	☐ Anemia
☐ Rheumatic Fever	☐ Tuberculosis	☐ Cancer	☐ Polio
☐ Epilepsy	☐ Arthritis	☐ Alcoholism	

MAJOR SURGERIES/ HOSPITALISATIONS

☐ Appendicitis	☐ Gallbladder	☐ Back surgery
☐ Tonsil	☐ Hysterectomy	☐ Other-Precise :_____
☐ Fractures		

MUSCULAR -SKELETAL

☐ Low back pain	☐ Pain between the shoulders	☐ Joint pain/Stiffness/Swelling	
☐ Arm pain	☐ Sciatic nerve	☐ Cold hands and feet	
☐ Neck pain	☐ Scoliosis	☐ Bursitis	
☐ Difficulties to walk	☐ Stiffness in general		

NERVOUS SYSTEM

☐ Nervosity	☐ Dizziness	☐ Stress	☐ Depression/confusion
☐ Numbness	☐ Convulsion	☐ Paralysis	

GENERAL

☐ Allergies	☐ Insomnia	☐ Sinusitis	☐ Bad blood circulation
☐ Tiredness	☐ Chronic bronchitis	☐ Asthma	
☐ Headaches	☐ Migraines	☐ Hay fever	

GASTRO-INTESTINAL

☐ Chronic diarrhoea	☐ Haemorrhoids	☐ Indigestion	☐ Frequent nausea
☐ Liver problem	☐ Gallbladder problems	☐ Ulcers	

GENITAL-URINARY	☐ Painful/excessive urinary	☐ Incontinence

EYES/EAR/ NOSE/THROAT	☐ Hum	☐ Tinnitus
	☐ Otitis	☐ Hearing difficulty

CARDIO-VASCULAR

☐ Chest pain	☐ Phlebitis	☐ Low blood pressure
☐ Angina	☐ Congested lungs	☐ Palpitations/ High blood pressure
☐ Infarct	☐ Swelling ankle	☐ 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

☐ P.M.S	☐ Breast pain	☐ Bumps on breast	M.T.S._____
☐ Excessive bleeding	☐ No menstrual	☐ Heat flash	Aids
☐ Menstrual irregularity	☐ Menstrual cramps	☐ Vaginites	Other _____
MEN ONLY	☐ Erective problems	☐ Prostate problems	M.T.S_____

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.***

_____ _____

Patient's Signature/ curator ***Date***