

ANAMNESIS (part 1)

IDENTIFICATION

Name _____

Birth Date: DD/MM/YYYY _____ Today's Date DD/MM/YYYY _____

Address: _____

City/Town : _____ Postal Code : _____

Tel. (Home): _____ Tel. (Work): _____

E-mail address: _____ Occupation: _____

How did you hear about the clinic? : Reference (patient's name): _____

Pages Jaunes directory Passer-by Publicity or kiosk Web site Other Professional Other

REASON OF CONSULTATION

Prevention Specific problem

1. Reason of consultation _____

2. How long have you been feeling these symptoms? _____

3. Are these symptoms a result of an injury, a trauma, a fall or another accident?

No Yes: _____

4. Is it the first time you feel this specific pain/ache? Yes No, it's the ___ time

5. Choose the number that best describes your level of pain : (None) 0 1 2 3 4 5 6 7 8 9 10 (Very high)

6. Do you feel pain: Everyday Constantly From time to time?

7. Is it worse: when you wake up during the day in the evening in the night?

8. What does relieve you? _____

9. Does your pain/ache worsen as time goes by each time it occurs

with certain movements or activities?

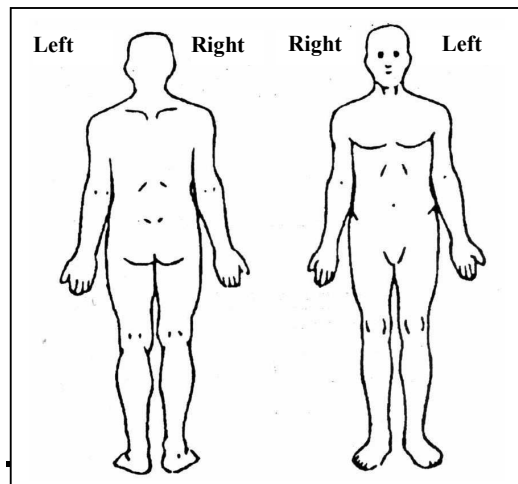
10. Does your pain restrain you to?

Work Sleep Walk Keep your day-to-day activities

11. Do you take medication, vitamins or natural products?

Which ones? _____

PAIN/ACHE LOCALIZATION



Please indicate on the picture which areas are affected

Pain : XXX

Numbness : - - -

Stiffness : / / /

ANAMNESIS (part 1)

1. Have you seen another professional about this particular problem/condition? Yes No
2. Are you Right handed? Left handed? 3. Do you wear plantar orthoses? _____

VERTEBRAL HEALTH HISTORY

1. When was your last visit to a chiropractor? _____
2. What type(s) of care did you receive?
 Relief Corrective Maintenance
3. Which techniques were used?
 Adjustments Muscular techniques Activator Ultrasounds, nerve stimulation
4. Which of the following vertebral problems have you ever had or suffered of :
 Car accidents (Dates : _____)
 Falls(Dates : _____)
 Excessive efforts : _____
 Contact sports: _____

LIFE HABITS

1. Do you work standing sitting other? : _____
2. What is your main task at work? _____
3. Do you have an ergonomic workstation at home? Yes No
4. Do you have an ergonomic workstation at work? Yes No
5. Do you keep your wallet in the back pocket of your trousers? Yes No
6. Do you cross your legs? Yes No 7. Do you make your articulations «crack»? Yes No
8. Is your mattress firm soft recent old?
9. How many pillows do you sleep with? ____
11. Do you put an arm under your pillow when you sleep? Yes No
12. Do you have a good quality of sleep? Yes No
13. What is your sleeping posture? on your stomach on your back on your sides (L or R)
14. Do you maintain a good posture at work? Yes No
On the couch? Yes No In general? Yes No
15. Which sports/physical activities do practice? _____
16. How often? _____
17. Do you smoke? No Yes Quantity/day? _____
18. What is your weekly average consumption of alcoholic drinks? _____
19. Choose the number that best describes your level of stress : (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

ANAMNESIS (part 1)

NAME :

DATE :

ANAMNESIS

Do you suffer or have you suffered of:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthrosis/ Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes/Hypoglycemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Faintings |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of dermal sensation (face, limbs...) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches, migraines |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/anxiety/nervousness/chronic fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea/vomiting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension or low pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation/diarrhea |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Digestive disorders (ulcer, acidity...) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidneys disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems (infarct, angina...) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness, vertigo |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulation disorders (obstructed artery, aneurysm...) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies/sinusitis/frequent colds |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear troubles (otitis, tinnitus...) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer or tumor/ radiotherapy, chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory disorders (asthma, tuberculosis...) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye disorders (myopia, spots of light, blurred vision...) | | |
- Other : _____

WOMEN SECTION

1. Are you pregnant? Yes No 2. Contraceptive method: _____
3. Are your menstruations: Regular Painful Abundant? 4. Are you menopausal? Yes No
5. Number of pregnancies: _____ 6. Complications: No Yes : _____

Statement For All

Our team is pleased to welcome you. As most of our patients you might have been referred to our clinic. Even though it is not the case, please be assured of our complicity in your way to an optimized health.

Today, a physical exam will be done by your doctor in chiropractic, which will allow to evaluate your condition. X-ray photographs will be taken on site. On your next visit, a detailed explanation of the results will allow you to make the most appropriate decisions about your health.

I hereby certify that I gave all the information required regarding my health and all information I gave are complete and true. I authorize the physical exam (or that of my child: _____) and if needed, the X-ray photography process. Also, I accept the responsibility of all charges as well as those that are not covered by my insurance company.

Signature : _____

Date : _____

Section reserved to D.C.

ANAMNESIS (part 2)

RAPPORT RADIOLOGIQUE

Nom : _____ Prénom : _____
 Date de naissance : _____ Date de la prise des radiographies : _____
 Vues **C/S**: ___ A/P ___ APOM ___ Lat. ___ Obl. ___ Flex. ___ Ext **T/S**: ___ A/P ___ Lat. **L/S**: ___ A/P ___ Lat. ___ Obl. ___ Flex. Lat.
 Autres: _____

<p>MINERALISATION OSSEUSE : <input type="checkbox"/> Normale</p> <p><input type="checkbox"/> Diminuée : +1 +2 +3 <input type="checkbox"/> Augmentée :</p>	<p>ALIGNEMENT PLAN FRONTAL : <input type="checkbox"/> Limite de la normale</p> <p><input type="checkbox"/> Inclinaison latérale G / D +1 +2 +3 de à</p> <p><input type="checkbox"/> Inclinaison latérale G / D +1 +2 +3 de à</p> <p><input type="checkbox"/> Déviation convexe à G / D +1 +2 +3 de à</p> <p><input type="checkbox"/> Déviation convexe à G / D +1 +2 +3 de à</p> <p><input type="checkbox"/> Rotation corps vertébral à G : <input type="checkbox"/> Rotation du corps vertébral à D :</p> <p><input type="checkbox"/> Tête fémorale G / D inférieure de mm</p>																		
<p>TISSUS MOUS : <input type="checkbox"/> Normaux</p> <p><input type="checkbox"/> Phlébolithiases pelviennes <input type="checkbox"/> Autres</p>	<p>ALIGNEMENT PLAN SAGITTAL : <input type="checkbox"/> Normal <input type="checkbox"/> ADI= mm</p>																		
<p>ANOMALIES CONGENITALES : <input type="checkbox"/> Aucune</p> <p><input type="checkbox"/> Asymétrie facettaire <input type="checkbox"/> Segment transitionnel <input type="checkbox"/> Pons posticus</p>	<p>Lordose C/S : <input type="checkbox"/> Normale <input type="checkbox"/> Hypolordose +1 +2 +3 de à</p> <p><input type="checkbox"/> Hyper +1 +2 +3 de à <input type="checkbox"/> renversée +1 +2 +3 de à</p>																		
<p>OSTEOARTHROSE : <input type="checkbox"/> Aucune</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Niveaux</th> <th style="width: 10%; text-align: center;">Degré</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Irrégularité/sclérose art. :</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Discopathie :</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Ostéophytose :</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Foramen invertébraux diminués :</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Ostéoarthrose :</td> <td></td> <td></td> </tr> </tbody> </table> <p><input type="checkbox"/> Les autres structures ; disques ; tissus mous ; facettes articulaires ; cortex sont sans remarque.</p>		Niveaux	Degré	<input type="checkbox"/> Irrégularité/sclérose art. :			<input type="checkbox"/> Discopathie :			<input type="checkbox"/> Ostéophytose :			<input type="checkbox"/> Foramen invertébraux diminués :			<input type="checkbox"/> Ostéoarthrose :			<p>Lordose L/S : <input type="checkbox"/> Normale <input type="checkbox"/> Hypolordose +1 +2 +3 de à</p> <p><input type="checkbox"/> Hyper +1 +2 +3 de à <input type="checkbox"/> renversée +1 +2 +3 de à</p>
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	<p>Ligne de gravité <input type="checkbox"/> L/S : N / ant / post. mm <input type="checkbox"/> C/S : N / ant mm</p>																		

Autres impressions radiologiques :

Signature : _____