DRE **Laura Benhaïm**
CHIROPRATICIENNE

Date:

Name: _____ First name: _____

Address: _____ City: _____

Postal code: _____ Email:_____

Home number: _____ Cell: _____

Work number:_____ ext: _____

Date of birth (dd/mm/yyyy): _____

Occupation: _____ Employer: _____

☐ Car accident (SAAQ)

☐ Work incident (CSST)

Who referred you to the clinic?

☐Colleague, friend, parent: _____

☐ Health professional: _____

☐ Google or other search engine ☐ Association / Order of chiropractors

☐ Publicity

☐ Other: _____

Life habits (circle)

Do you smoke? yes / no

Usually, you sleep on the... : back / stomach / side

How many hours of physical activities? ____/week

Adequate desk ergonomics: yes / no

Quality of nutrition: excellent / normal / inadequate

What would you like to improve about your nutrition?_____

Coffee: ___/week Alcoholic drinks: ___/week

Do you drink energy drinks? no / yes, ____/week

Level of stress: 0 1 2 3 4 5 6 7 8 9 10 (0 = none)

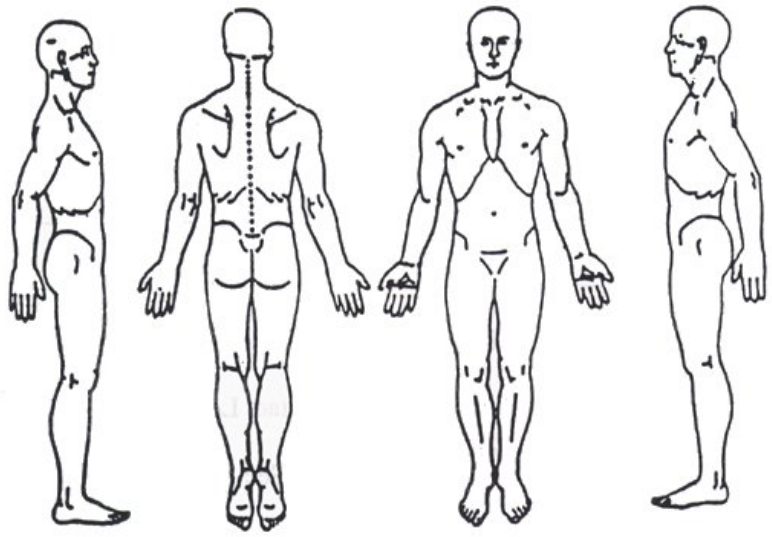
How important is your health to you:

0 1 2 3 4 5 6 7 8 9 10 (0=none)

What would you like to improve about your health? _____

ATTENTION: Chiropractic care is not covered by public health insurance (RAMQ) For any appointment cancellation or modification, you must let us know 24hrs in advance. Otherwise, fees of $40 could be applied. Initials:_____

Please indicate the locations of your pain(s):



A) Please indicate on the line the proportion of the pain:

No pain ——————————————————————— Extreme pain

B) Have you had (○) or do you presently have (□) the following disorder/disease/problem:

Past	Present	
○	□	Allergies
○	□	Affection of the thyroid gland
○	□	Anemia or blood disorder
○	□	Arthritis or rheumatism
○	□	Cancer, cyst or tumor
○	□	Cracking or pain (jaw)
○	□	Depression or anxiety
○	□	Diabetes or hypoglycemia
○	□	Ecchymoses
○	□	Numbness
○	□	Sprain, tendinitis ou bursitis
○	□	Epilepsy or convulsions
○	□	Dizziness ou vertigo
○	□	Fatigue
○	□	Fracture
○	□	Chills or fever
○	□	High or low blood pressure
○	□	Urinary or stool incontinence
○	□	Insomnia
○	□	Skin disease

Past	Present	
○	□	Neck pain
○	□	Back pain
○	□	Headaches or migraines
○	□	Nauseas
○	□	Edema (swelling)
○	□	Loss or gain of weight recently
○	□	Heartburns
○	□	Eye or ear disorder
○	□	Heart failure
○	□	Respiratory difficulties
○	□	Digestive problems
○	□	Hormonal problems
○	□	Renal problems
○	□	Blood in urine or stools
○	□	Urinate frequently
○	□	Prostate problems

Section for women only

○	□	Painful menstruations
○	□	Menopause signs

C) **What are you looking for:** temporary relief durable correction optimal health

I solemnly declare that all the information provided in this form is correct and exact to the best of my knowledge

_____ _____

Signature Date