File Number:_____ **OPENING FILE (1)**

Name: _____First name:_____ Sex: F ❒ M ❒

Address:_____ Date of birth: yy_____ / mm_____ / dd _____

City:_____ Married ❒ single ❒ widow ❒ Div. ❒ Partner ❒

Postal code:_____Home✆_____ Occupation:_____

Cell.✆ _____Work✆_____E-Mail_____

Insurances for chiropractic: Yes ❒ No ❒ **?** ❒

Recommended you to our clinic: _____Friend ❒ Family ❒ Acquaintances ❒

Found out about the clinic: Yellow Pages ❒ outside sign ❒ Publicity ❒ Flyer ❒ Internet ❒ Other ❒_____

1.**Main problem** for this first your consultation?

_____

_____

_____

2. **Other problems** in order of importance:

_____

_____

_____

3. **Your expectations:**_____

_____

_____

Main problem

4. Since when?_____

5. Started Gradually ❒ Suddenly ❒
   From accident ❒ Trauma ❒ Ignore ❒

6. Present _____% of the time.

6. Condition getting worst ❒ better ❒ the same ❒

7. Worse in morning ❒ day ❒ evening ❒ night ❒

8. Harm your work ❒ sleep ❒ routine ❒

9. Deprive you of your work ❒ sleep ❒ routine ❒

10. You have already consulted (name and title)

_____

Details:_____

Results:_____

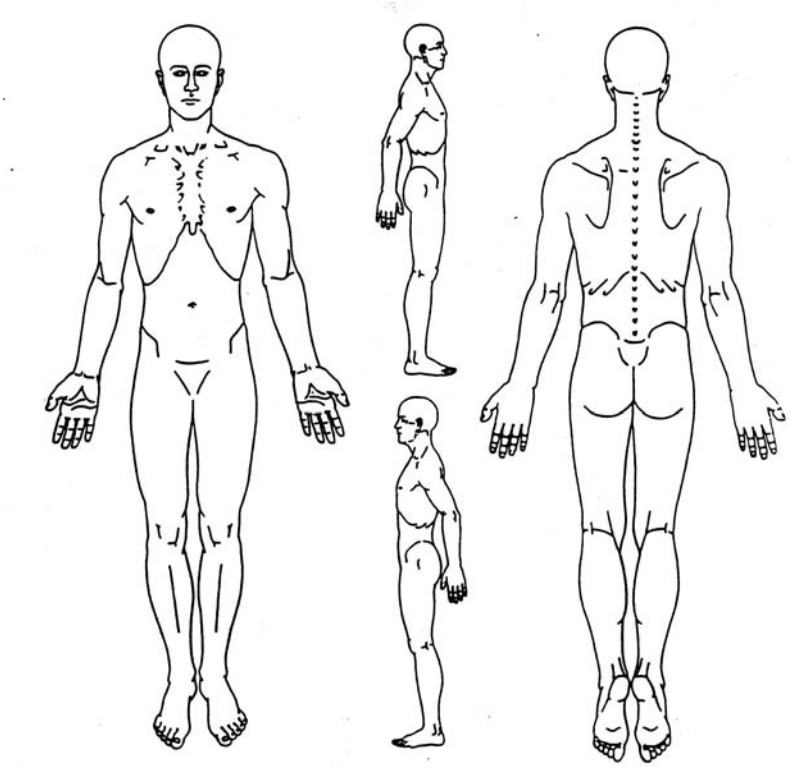
11. Same problem before: Yes ❒ No ❒ When_____

_____

Details_____

Results:_____

Please indicate on the drawings, the exact location of your problems.



Check the box that indicates the severity of your main problem.

No pain **extreme pain**

❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
0	1	2	3	4	5	6	7	8	9	10

Date of your last examination :

	less than 6 months	6-18 mo.	more than 18 months	never
Chiropractic	❒	❒	❒	❒
Physical	❒	❒	❒	❒
Radiological	❒	❒	❒	❒
Blood	❒	❒	❒	❒
Urine	❒	❒	❒	❒

Opening File (2) File_____

FAMILY HISTORY:

1-Father: age____ If deceased, cause_____

2-Mother:age____ If deceased, cause_____

3-You have____sisters ____brothers

4-Do members of your family have:

Cardiac problems ❒ Cancer ❒

Diabetes ❒ Arthritis ❒ Other ❒ ?

Taking medications now? Yes ❒ No ❒

Muscular relaxants ❒ Pain killers ❒
Anti-inflammatory ❒ Anti-coagulant❒
Hormones ❒
For: high blood pressure ❒ Diabetes ❒
thyroid gland ❒ Birth Control: ❒
Others: prescribed or over the counter:
_____
_____
_____

Position at your work?
Standing ❒ Sitting ❒ Moving ❒
Wearing shoe lifts ❒ or orthotics ❒

Sleeping normally on your
back ❒ side ❒ stomach ❒
Normal night sleep: _____hours
You consume
Cigarettes _____/day

Drinks of alcohol _____/day / week

Coffees or teas_____/day / week

Vitamins or food supplements Yes ❒ No ❒
_____
_____

Exercising ____times/ week ____hours/ week
Describe_____
_____
_____
Practiced Sports:_____
_____
_____

Present: (PR) Past: (PA)

	(PR)	(PA)	
1.	❒	❒	Allergies
2.	❒	❒	Anxiety
3.	❒	❒	Arthritis
4	❒	❒	Abdominal gas
5.	❒	❒	Low blood pressure
6	❒	❒	Constipation
7.	❒	❒	Convulsions
8.	❒	❒	Itching
9.	❒	❒	Depression
10.	❒	❒	Diabetes
11.	❒	❒	Diarrhea
12.	❒	❒	Easily bruised
13.	❒	❒	Numbness
14.	❒	❒	Epilepsy
15.	❒	❒	Skin eruptions (redness)
16.	❒	❒	Dizziness/vertigo
17.	❒	❒	Loss of consciousness
18.	❒	❒	Cold extremities
19.	❒	❒	Fatigue
20.	❒	❒	Fractures
21.	❒	❒	Shivers
22.	❒	❒	High blood pressure
23.	❒	❒	Hypoglycemia
24.	❒	❒	Urinary incontinence
25.	❒	❒	Insomnia
26.	❒	❒	Irritability
27.	❒	❒	Hereditary diseases
28.	❒	❒	Back pain
29.	❒	❒	Headaches
30.	❒	❒	Meningitis
31.	❒	❒	Edema (swelling)
32.	❒	❒	Operations/surgery

	(PR)	(PA)	
33.	❒	❒	Loss or gain of weight
34.	❒	❒	kidney stones
35.	❒	❒	Shaking
36.	❒	❒	Foot problems
37.	❒	❒	Cardiac problems
38.	❒	❒	Blood circulation problems
39.	❒	❒	Respiratory problems
40.	❒	❒	Eye problems
41.	❒	❒	Digestive problems
42.	❒	❒	Sexual problems
43.	❒	❒	Hearing problems
44.	❒	❒	Hormonal problems
45.	❒	❒	Psychological problems
46.	❒	❒	Kidney problems
47.	❒	❒	Varicose vein problems
48.	❒	❒	Nose bleeds
49.	❒	❒	Blood in the stools
50.	❒	❒	Blood in the urine
51.	❒	❒	Sinusitis
52.	❒	❒	Urinate frequently
53.	❒	❒	Urinate at night
54.	❒	❒	Prostate problems
55.	❒	❒	Cancer

Section reserved for woman

56.	❒	❒	No menstruation
57.	❒	❒	Abdominal cramps
58.	❒	❒	Abundant menstrual flow
59.	❒	❒	Painful menstruation
60.	❒	❒	Vaginal loss
61.	❒	❒	Menopause symptoms

62. Are you pregnant?
Yes ❒ No ❒ May be ❒

PAYMENTS:
X-ray films, examinations and chiropractic treatments are payable at each visit, unless prior financial arrangements have been made. **X-ray films remain the property of the clinic.**

DECLARATION FOR ALL:
I declare that the information given on this form is complete and exact and I consent to receive any necessary examinations.
SIGNATURE:_____ DATE:_____