Dr. Sima Goel D.C.
Chiropraticienne
Family chiropractor

6900 Decarie, Suite 340, Montreal, Quebec H3X 2T8

Health Questionnaire

Welcome! This form is very useful in helping us help you. Please take your time to complete it fully. Thank you

PERSONNAL INFORMATION

First Name : ______________________ Birth Date : day____/mo.____/yr.____

Last Name : ______________________ Age : ________

Address : ______________________ Civil Status : Single❑ Married❑ Common law❑ Divorced❑ Widow❑

Apt # : _

Email Add : ______________________

____

City : ______________________ Occupation : ______________________

Postal Code : ______________________ Employer : ______________________

Tel. (res.) :
Tel. (off.) : ______________________

Cellular : ______________________

Method of payment
Cash ❑ VISA❑ Check❑

Spouse's Name :		
Their occupation :		
Name & ages of children :	1.	4.
	2.	5.
	3.	6.

1-The majority of people that consult us have been referred by one of our patients. Who can we thank? __________________

2-Reason for the consultation: Health concern ❑ Prevention ❑ Pregnancy ❑ Other ❑

3-How long since your last Chiropractic exam?_______________ Chiropractor : _________________________

4-Did you receive care resulting from your exam? The results where : satisfactory❑ averages❑ disappointing❑

DESCRIBE THE SYMPTOMS YOU FEEL

Identify on the diagrams below your areas of concern	Describe, in it's order of importance to you, the health concerns that you wish to improve.
	1. Resulting from: accident❑ progressive irritation❑ slowly❑ Since when?
	2. Resulting from: accident❑ progressive irritation❑ slowly❑ Since when?

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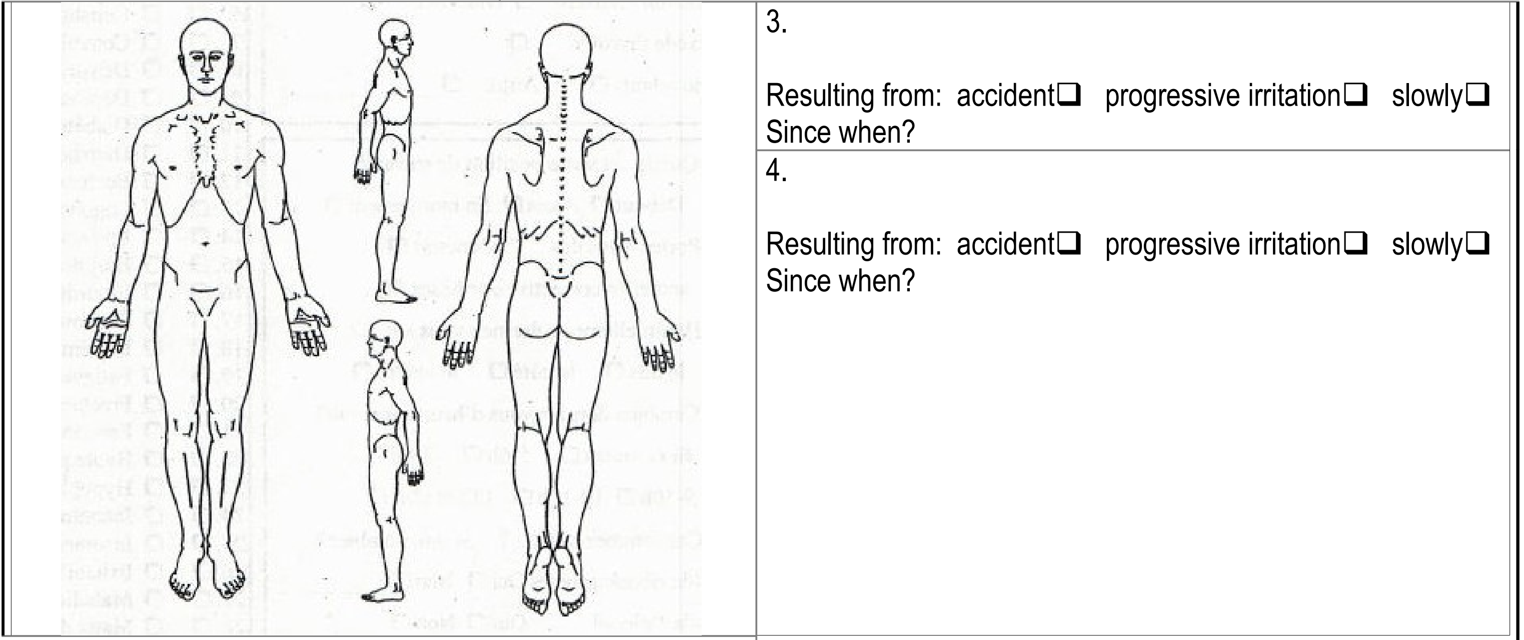

3.

Resulting from: accident❑ progressive irritation❑ slowly❑
Since when?

4.

Resulting from: accident❑ progressive irritation❑ slowly❑
Since when?

Who in your family suffers from the same health concerns as you? Indicate the corresponding number below.

Child_____ Spouse _____ Parent_____ Brother / Sister_____ Other_____

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HISTORY OF YOUR HEALTH CONCERNS

1-Have consulted a professional for the symptoms indicated?	None❑ Chiropractor❑ Medical Doctor❑ Other ❑
2-How have your symptoms and health concerns changed?	1- improved❑ deteriorated❑ unchanged❑ 2- improved❑ deteriorated❑ unchanged❑ 3- improved❑ deteriorated❑ unchanged❑ 4- improved❑ deteriorated❑ unchanged❑
3-Identifiy which health concerns have previously occurred :	1❑yr_____ 2❑yr_____ 3❑yr_____ 4❑yr_____
4-Do these health concern decrease your quality of life :	at work❑ at home ❑ leisure❑ sleep❑ other❑
5-Does your primary health concern (1) affect you :	100% of the time❑ 75%❑ 50%❑ 25%❑ less de 25%❑
6-Your primary health concern(1) is aggravate by which positions:	standing❑ sitting❑ lying down❑ other_______________
7-Do you take any medication for this health concern? (1)	No❑ Yes❑ : ________________________
8- Do you take any medication on a regular basis?	no❑ anti-inflammatory❑ muscle relaxants❑ blood pressure meds.❑ antidepressants❑ thyroid med.❑ diabetic meds.❑ contraceptive❑ other❑

FAMILY HISTORY

1-Mother's age :	If deceased, cause :
2-Father's age :	If deceased, cause :
3-Does someone in your family suffer from one or more of the following :	Heart disease❑ Diabetes❑ Artthritis❑ Cancer❑ Other :

LIFE HABITS

1-Working posture? :	standing❑ sitting❑
2-Foot orthotics?	yes❑ no❑
3-Sleep per night :	8h+❑ 6-8h❑ under 6h❑
4-Sleep position :	back❑ side❑ stomach❑
5-Excercise per week :	4h+❑ 2-4h❑ 1-2h❑ under 1h❑ never❑
6-Usage : (circle : day or week)	Tobacco : /day or week Alcohol : /day or week Coffee : /day or week

SYSTEM REVIEW – identify the symptoms and concerns you are familiar with.

❑Allergies	❑Convulsions	❑Fracture	❑Irritability	❑Shivers
❑Anxiety	❑Depression	❑Frequent urination	❑Kidney stones	❑Sinusitis
❑Arthritis	❑Diabetes	❑Gas	❑Low blood pressure	❑Surgery
❑Back pain	❑Diarrhea	❑Head ache	❑Meningitis	❑Swelling
❑Blood in your stool	❑Digestive difficulties	❑Hearing difficulties	❑Nose bleeds	❑Tremors
❑Blood in your urine	❑Dizziness	❑Heart disease	❑Numbness	❑Urination at night
❑Bruising	❑Eczema	❑Hereditary illness	❑Prostate	❑Urinary incontinence
❑Cancer	❑Épilipsie	❑High blood pressure	❑Psychological issues	❑Varicose veins
❑Circulatory disease	❑Fainting	❑Hormonal difficulties	❑Renal difficulties	❑Vision difficulties
❑Cold extremities	❑Fatigue	❑Hypoglycemia	❑Respiratory disease	❑Weight difficulties
❑Constipation	❑Foot problems	❑Insomnia	❑Sexual difficulties	
Feminine Section	❑Lack of menstruation	❑Abdominal cramps	❑Abundant menstrual flow	
❑Vagina discharge	❑Menopause symptoms	Are you pregnant? Yes❑	NO❑	maybe❑

-All professional fees associated with chiropractic care, the examination and radiographic films are payable according to the clinic policies. The patient's file including radiographs belong to the clinic and must remain at all times.

-The information provided is truthful and accurate to the best of my knowledge. I also agree to the recommended examinations.

Signature :____ _____Date :__________________