Clinique Chiropratique du Dr Riccardo J. Cifola

Personnel file

PLEASE COMPLETE

Maiden name :_____ **First name:** _____

Address: _____

City : _____ **Postal code:** _____

Tel. home : _____ **Tel. work :** _____

Date of birth : _____ **Age :** _____

Status : **Single** _____ **Married** _____ **Divorced** _____ **Widow** _____

Spouse's name : _____ **Number of children:** _____

Date :_____

Family doctor : _____

Specialist doctor: _____

Last exam :_____

Refered by : _____

Insurance for chiro : yes _____ **no** _____

Your profession / work: _____

Hobbies : _____

Reasons for consultation : _____

_____

Is it for : _____ **corrective** _____ **preventive** _____ **relief care.**

AT THE PRESENT:

Your pain is qualified as :

_____ **intense** _____ **pressure** _____ **shooting** _____ **numbness**

_____ **burning** _____ **pinching** _____ **itching** _____ **pulsating**

When it happened, you were :

_____ **standing** _____ **bent over** _____ **sitting**

_____ **lying down** _____ **squatting** _____ **twisted**

When is the pain more intense :

_____ **day** _____ **week ends** _____ **season**

_____ **night** _____ **end of month** _____ **constant**

SURGICAL OPERATIONS

Date: _____

Type: _____

Localize scars: _____

DENTAL CARE

Date : _____

Type : _____

DO YOU TAKE MEDICATIONS ?

Which one: _____

_____

_____

Do you take supplements or vitamines ?

Which one: _____

_____

MRS OR MISS

Date of your last period: _____

Regular cycle ? _____ **yes** _____ **no**

Do you suffer from P.M.S. ? _____ **yes** _____ **no**

Are you pregnant ? _____ **yes** _____ **no**

If yes, number of weeks : _____

Date of last gynecological examination : _____

Describe your menstrual problems : _____

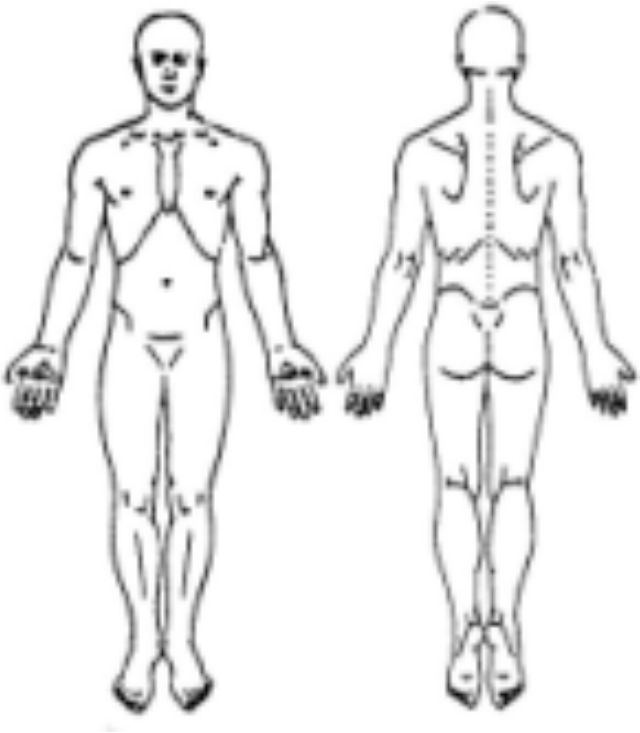
_____

_____

_____

INDICATE THE PAINFUL AREAS AND DESCRIBE THEM BRIEFLY

Type of pain: ____ deep ____ superficial
____ dull ____ sharp
____ radiating ____ localized



INTENSITY/SEVERITE

(1) little / (10) very much: _____
Aggravated by: _____
Improved by: _____

This pain affects my quality of life during ?
_____ office _____ play
_____ sleep _____ family life

Have you ever been treated for this ailment? _____ yes
_____ no
If yes, when?
_____
By whom ?
_____
The results were: _____ none _____ moderate _____ good
_____excellent

YOUR HEALTH

Enumerate accidents, date and type of care received (include falls, sprains, fracture, etc.)

_____
_____

Have you had any car accidents? _____ yes _____ no

Indicate the type of collision: _____ frontal _____ side way ____rear____ turn over

Were you the? ____ driver _____ passenger _____ front
_____ rear _____ buckled up _____unbuckled

INDICATE THE FREQUENCY OF YOUR SYMPTOMS

J (daily) / H (weekly) / M (monthly)

Asthma/shortness of breath		**Back pain**	
Cold / influenza		**Breast tenderness (mastitis)**	
Constipation		**Bruises easily (ecchymoses)**	
Cough dry/mucous		**Heel pain (fascitis / spur)**	
Digestive discomfort		**Hemorroids**	
Dizziness / vertige		**Irregular / painful menstruation**	
Earache (otitis)		**Numbness in hand / fingers (carpel tunnel)**	
Fatigue / lack of energy		**Rib cage discomfort**	
Insomnia		**Sciatica**	
Migraine/headache		**Skin rash (eczema/urticaria)**	
Neck pain		**Swollen joints**	
Seasonal allergies		**Tendonitis /bursitis / epicondylitis**	

INDICATE FAMILY ILLNESSES

(father, mother, siblings, grandparents)

Diabetes		**Cancer**	
Cardiovascular		**Blood pressure**	
Hypoglycemia		**Liver**	
Arthristis		**Other**	

ANY ADDITIONNAL COMMENTS :

PEDIATRIC QUESTIONNAIRE

Date of consultation: _____ Referred by: _____

Last name: _____ First name: _____

Address: _____ City: _____

Postal Code: _____ Phone at home: (____)_____

Child's birth date: _____

Mother: _____ Phone at work :(____)_____

Father: _____ Phone at work: (____)_____

Payments will be made by:_____

How can we help: _____

Delivery was:

Natural ____ Induced ____ C-section ____ Suction ____ Forceps ____

Total length of labour: _____

Liquid foods

Breastfeeding ____ Prepared ____

Solid foods

Fruits____ vegetables ____ Cereals ____ Legumes ____ Meats ____

Medication : _____

Supplement: _____

Comments : _____

_____

_____