Dre Anissa St-Jean, DC ☐
Dr Denis St-Jean, DC ☐

Clinique Chiropratique Hawkesbury
130 Principale Ouest,
Hawkesbury, Ontario
K6A 2H2
T : 613-632-0953, 613-632-0954,

Opening file date :

Opening File

PERSONAL INFORMATION

First name and Name : Sex : M O F O		**Date of birth :**
Address :		Home **phone** number: Can we leave a message at this number? Yes O No O
		Work phone number :
E-mail:		Cellular number:
Occupation :		How would you prefer us to call you for your appointment? By E-mail : O By phone ,the day before : O
Civil status : Divorced O Single O Law spouse O Married O Widow/Widower O	Do you have **children**? : Yes O No O If yes, how many? :	*Who recommended you to our clinic?* O Facebook O Phone book O Publicity O Someone told me about you. Tell us who to thank for the reference:

REASON FOR CONSULTATION

What is your **reason** to see the Dr(e) St-Jean ?

Describe **how** and **when** your main problem first appeared :

How do you grade your pain **on a scale** 0 to 10? At rest : **/10** with activity: **/10**

What factors **aggravate** your pain? What are the factors which **lower** the pain?

SYSTEM REVIEW

Have you ever had a disease of the:	Yes	No	Please specify if necessary
Eyes, nose, mouth or ears?	O	O	
esophagus, stomach, liver, throat or lung?	O	O	
Gall bladder or intestine ?	O	O	
Heart problem, arterial pressure, cholesterol or blood?	O	O	
Thyroid problem, diabetes or hormone?	O	O	
Skin problem, ligament, muscular, joint or bone problem?	O	O	
Do you have headaches? How often?	O	O	

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LIFE HISTORY

Known disease? None O If yes, specify	**Surgery/ Hospitalisation?** None O If yes, specify	**Allergies?** None O If yes, specify
Accident / Traumas? (car, sport, various) None O If yes, specify	Do you take **medication?** None O **Family Doctor :**	

PILLARS OF HEALTH

Do you consume...? If yes, how many/much? -cigarettes yes O _____ No O -alcohol yes O _____ No O -coffee/tea yes O _____ No O -Drugs yes O _____ No O -Energy drinks yes O _____ No O	**How many glasses of water do you usually drink per day?** **Do you take natural products?** yes O No O If yes, which one?	**Sleep** # of hours every night : Position of sleep : On the left side, right side, back, stomach? **Exercices** Type of exercice : # of time per week :

FAMILY HISTORY Are there some diseases that occur most often in your family? (cancer, cardiac trouble,diabetes etc.) ?	**You are looking for what kind of care?** O relief of symptoms only O durable relief and prevention of the spine O The choice of treatment plan of Dr(e) St-Jean

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