O'CONNOR HEALTH GROUP
Your Head-To-Toe Health Care Centre

Dr Gabrielle Pomerleau, D.C.
Chiropractor / Chiropraticienne

Date:_____

PERSONAL INFORMATION

Last Name: _____ **First Name**: _____

Date of Birth: YYYY/MM/DD **Age:** _____ **Gender:** _____ **Height:** _____ **Weight**_____

Address: _____ **City:** _____ **Postal Code**_____

Contact information:

Location	Phone Number	Please √ Best # to Contact
Home		
Work		
Cell		
Email		

Marital Status: _____**Spouse's name**_____

Number Children: _____ **Name and Age:** _____

Occupation:_____ **Employer**:_____

Is this consultation in relation with a car accident or work related injury? ☐ No ☐Yes

How did you hear about our clinic? _____

Have you ever received Chiropractic treatment? ☐ No ☐Yes, When _____

Name of Family Physician: _____ **Date of Last Visit:**_____

Are you seeing any other Health care professionals? _____

_____

What are your 3 main goals regarding your health?

- _____
- _____
- _____

Would you like to receive our monthly newsletter? ☐ No ☐Yes

O'CONNOR HEALTH GROUP
Your Head-To-Toe Health Care Centre

Dr Gabrielle Pomerleau, D.C.
Chiropractor / Chiropraticienne

WHAT BRINGS YOU TO OUR OFFICE ?

Describe your chief complaint(s): _____

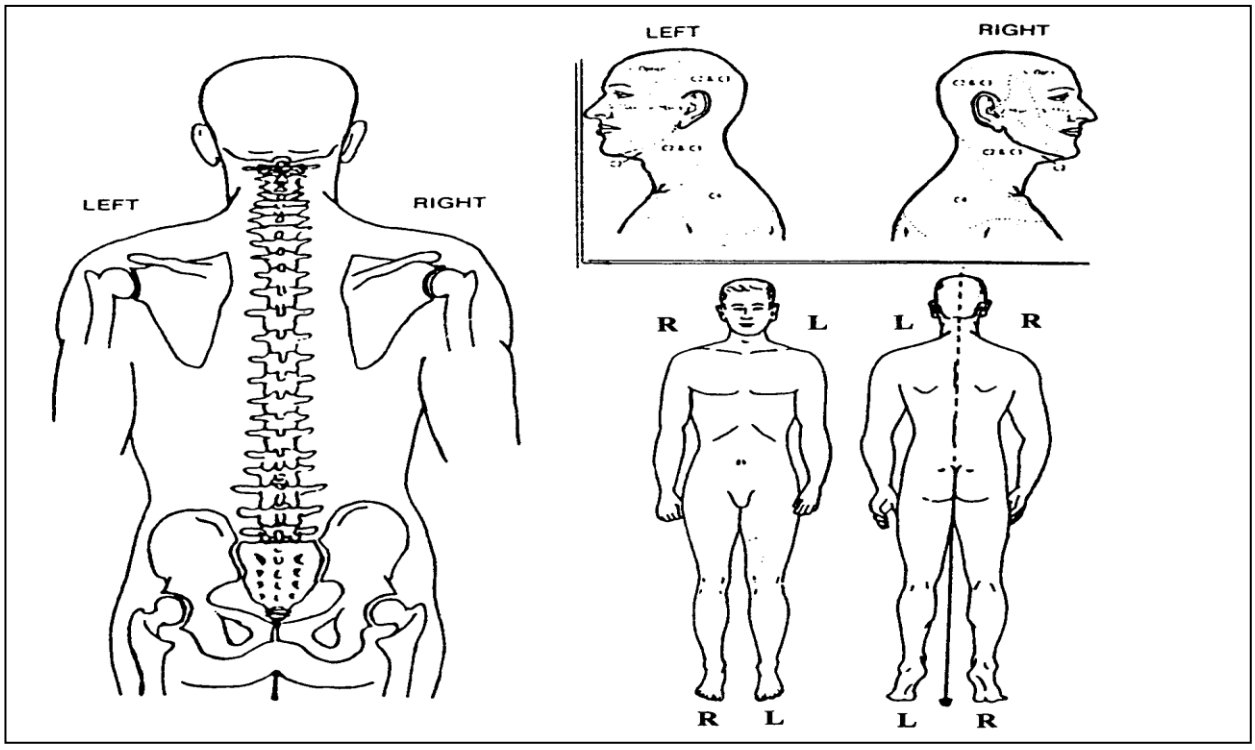
_____

Secondary complaint: _____

How did these problems begin?_____

How long have you had them:_____

Please indicate on the diagrams the location of your problems. (Please number them in order of importance.)



Rate on a scale of 0 to 10 (where 0 stands for "no pain" and 10 for "extreme pain") the severity of your symptoms

Chief Complaint: _____/10 Secondary complaint: ____/10

What did you try to relieve pain so far? _____

_____

O'CONNOR HEALTH GROUP
Your Head-To-Toe Health Care Centre

Dr Gabrielle Pomerleau, D.C.
Chiropractor / Chiropraticienne

GENERAL HEALTH HISTORY

PLEASE CHECK ALL that apply to you now or in past 6 months.

- ☐ Allergies
- ☐ Arthritis
- ☐ Appendix problems
- ☐ Asthma
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Vertigo
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Migraines
- ☐ Insomnia
- ☐ Chronic fatigue
- ☐ Memory loss
- ☐ Nervousness
- ☐ Numbness
- ☐ Hearing loss
- ☐ Ear infection
- ☐ Ringing in the ears
- ☐ Sinusitis
- ☐ Sneezing
- ☐ Vision problems
- ☐ Hyper-Hypoglycemia
- ☐ Diabetes
- ☐ Abdominal pain
- ☐ Thyroid problem
- ☐ Bowel problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Excessive hunger
- ☐ Poor appetite
- ☐ Excessive thirst
- ☐ Craving sweets
- ☐ Fluid retention
- ☐ Heart burn
- ☐ Gastric ulcer
- ☐ Gall bladder attacks
- ☐ Liver trouble
- ☐ Pancreatitis
- ☐ Nausea
- ☐ Vomiting
- ☐ IBS
- ☐ Hemorrhoids
- ☐ Impotence
- ☐ Bladder infections
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Speech difficulty
- ☐ Lung problems
- ☐ Persistent cough
- ☐ Sore throat
- ☐ Bronchitis- pneumonia
- ☐ Chest pain
- ☐ Heart condition
- ☐ Hypertension
- ☐ Varicose veins
- ☐ Strokes
- ☐ Reproductive disorders
- ☐ Testicular/ovarian problems
- ☐ Dysmenorrhea
- ☐ Prostate problems
- ☐ Cancer
- ☐ Weight gain/loss
- ☐ Pregnancy past or current

INJURIES: (Please describe)

Major falls/accidents: _____

Car accident: _____

Head injuries & concussion: _____

Surgery & hospitalization: _____

Broken bone: _____

Have you ever had X-rays, MRI, CT scans? _____

O'CONNOR HEALTH GROUP
Your Head-To-Toe Health Care Centre

Dr Gabrielle Pomerleau, D.C.
Chiropractor / Chiropraticienne

HEALTH HABIT:

Typical week exercises:_____

Sleep: Average number of hours: _____, Sleeping posture: _____,

Alcohol: _____/week Tobacco:_____/day Coffee/Tea:_____/week Drugs: _____

Medications:_____

FAMILY HISTORY:

Do any members of your family suffer from:

□ Heart disease, □ Cancer, □ Diabetes, □ Arthritis, □ Others:_____

PATIENT EXPECTATION:

I think that my health problems will be solved :

□ Instantly (few days)

□ In a few weeks

□ In a few months

□ I will have a better idea after the Chiropractor has explained the results of His examination

PATIENT'S STATEMENT:

If you have been diagnosed or tested positive for H.I.V., or any other immunological disorder, it is important you discuss the results, in private, with your chiropractic doctor.

I declare that all the information given is complete and exact. I authorize the chiropractic doctor to carry out the examination and provide me with the necessary care to improve my health.

Patient's Signature _____ Date_____

(Or legal guardian)

Section reserved for the doctor. Please do not write here.

Patient accepted □Yes □No Patient referred □Yes □No

DOCTOR'S COMMENTS: