

CLINIQUE CHIROPRACTIQUE BEAUREGARD

HEALTH HISTORY

Please fill out this form as completely and accurately as possible

Date _____

PERSONAL DATA

Name _____ Age _____ Date of birth _____

Name of parents (si moins de 18 ans) _____

Adresse _____ City _____ Province _____

Zip Code _____

Home phone(____) _____ Business Phone (____) _____

Cell Phone (____) _____ E-mail _____

Occupation _____ Employer _____

Emergency Contact _____

Marital Status S M D W L/W Conjoint(e) _____

Name and age of children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel the Clinique Chiropratique Beauregard can address for you?

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N Name of D.C. _____

How long under care? _____ days _____ weeks _____ months years _____

Date of last visit: _____ Why did you stop? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

Medical Physician Naturopath Acupuncturist Homeopath
 Massage Therapist Psychotherapist Energy Healer Dentist

Reason why: _____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature: _____ Date: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife _____

Where do you want to give birth? Hôpital Maison Centre de naissance Autre _____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the
SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and **how they may relate to your present spinal, nerve and health status**.

PRESENT AND PAST CONDITIONS

Allergies	<input type="checkbox"/> O	<input type="checkbox"/> N	Cardiac probl.	<input type="checkbox"/> O	<input type="checkbox"/> N
Anxiety	<input type="checkbox"/> O	<input type="checkbox"/> N	Immune syst. probl.	<input type="checkbox"/> O	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> O	<input type="checkbox"/> N	Infertility	<input type="checkbox"/> O	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> O	<input type="checkbox"/> N	Kidney diseases	<input type="checkbox"/> O	<input type="checkbox"/> N
Back pain	<input type="checkbox"/> O	<input type="checkbox"/> N	Menstrual cramps	<input type="checkbox"/> O	<input type="checkbox"/> N
Bladder problem	<input type="checkbox"/> O	<input type="checkbox"/> N	Mood swings	<input type="checkbox"/> O	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> O	<input type="checkbox"/> N	Neck pain	<input type="checkbox"/> O	<input type="checkbox"/> N
Circul/vascul probl.	<input type="checkbox"/> O	<input type="checkbox"/> N	Numbness	<input type="checkbox"/> O	<input type="checkbox"/> N
Depression	<input type="checkbox"/> O	<input type="checkbox"/> N	Tingling	<input type="checkbox"/> O	<input type="checkbox"/> N
Diarrhea	<input type="checkbox"/> O	<input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> O	<input type="checkbox"/> N
Digestive probl.	<input type="checkbox"/> O	<input type="checkbox"/> N	Sinus probl	<input type="checkbox"/> O	<input type="checkbox"/> N
Dizziness	<input type="checkbox"/> O	<input type="checkbox"/> N	Skin probl.	<input type="checkbox"/> O	<input type="checkbox"/> N
Headache	<input type="checkbox"/> O	<input type="checkbox"/> N	Urinary difficulties	<input type="checkbox"/> O	<input type="checkbox"/> N
Heart burns -reflux	<input type="checkbox"/> O	<input type="checkbox"/> N	Vertigo	<input type="checkbox"/> O	<input type="checkbox"/> N
			Others _____	<input type="checkbox"/> O	<input type="checkbox"/> N

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how you were birthed. (If you do not know, please skip to next question)

- Home Natural Hospital Caesarian section Forceps
 Breech Cord around neck Prolonged labor Drug induced labor Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (check all that apply)

- Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, state **type of injury and date:**

Have you ever **hurt/injured your** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? Y N

If yes, state **type of injury and date:**

Have you ever **hurt, broken, fractured or sprained** any bones or joints? Y N

If yes, list **body parts injured and dates:**

Have you ever been hospitalized? Y N

If yes, **state reason and dates:** _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated**? Y N If yes, did you have a **reaction**? Y N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Toxic chemicals | <input type="checkbox"/> Second hand smoke | <input type="checkbox"/> Drug therapy |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other |

If yes, please list: _____

Do you have **allergies** to any foods? Y N **If yes, please list:** _____

Do you **consume** any of the following presently?

- Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Please list all medications (prescribed and over the counter): _____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? Good Fair Poor

How do you grade your **emotional/mental health**? Good Fair Poor

How do you rate your overall **"quality of life"**? Good Fair Poor

Do you **exercise** regularly? If yes, how often? _____

Do you take **supplements**? If yes, please list: _____

Do you follow a **special dietary regime**? If yes, what? _____

EXPECTATIONS

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- Relief of a symptom or problem
- Relief and Prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health on all levels

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. (Please read booklet attached). The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

FINANCIAL INFORMATION

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

. Please indicate your method of payment: Cash Check

First visit : 60\$/adult 50\$/ student
Your first appointment includes :
The opening of your record
A consultation with your chiropractor
An exam of your nervous system
Your first adjustment

X-ray (full spine) : 100\$
X-ray (section) : 40-50\$/section

«À la carte»

(an adjustment) : 42\$- adult 32\$- student

«One month of unlimited cares»

335\$- adult 250\$- student
(Initial/intensive cares, 3-5 adjustment per week depending of the need)

«Two months of wellness cares»

(Cares included in a pro-active life style; 1 adjustment per week, sometime 2 as needed)

One person : 125\$/month- adult 95\$/month- student
Couple : 230\$/month
Family : 350\$/month

«One year of wellness cares»

(Cares included in a pro-active life style; 1 adjustment per week, sometime 2 as needed)

One person : 1250\$- adult 950\$-student
Couple : 2300\$
Family : 3200\$

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Martin Beauregard, D.C. and Dr. Suzanne Beauregard, D.C. permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature _____ Today's Date _____

Signature of Parent (for minor): _____ Today's Date _____

***Thank you for choosing The Clinique Chiropratique Beauregard.
We look forward to helping you.***