PERSONNAL INFORMATION

Name:	_____	First name:	_____
Address:	_____	City:	_____
Postal code:	_____	Telephone:	_____
Cellular:	_____	Work tel.:	_____
Birth date:	_____ Sex : M☐ F☐	Email:	_____
Occupation:	_____		

How did you hear about us? _____
Are you referred by another professional? If so, who? _____
Reason of referral: _____

Please give your consent to receive our monthly newsletter by email. In the latter, you will find our specials, training schedules, professional's weekend dates, replacements and schedule changes or all other important information pertaining to the clinic. In addition, every month we offer free information and tips on how to maintain or improve your health. Only one email is sent by month (except in some rare occasions) and you can unsubscribe at any time. Lastly, your email address will only be used by our clinic; no other business has access to it. *Please put your initials in order to receive the clinic's monthly newsletter:* _____

MEDICAL HISTORY

Please fill out date and circumstances of the following:
Motor vehicle accident: _____
Fall or severe trauma: _____
Head injury/depression/burn out:_____
Surgery (year): _____
Traumatic injury back/neck: _____
Fracture/tear/sprain: _____
Cancer (location, year): _____
Family doctor: _____

MEDICAL CONDITIONS

Circle if the following concerns to you and explain if necessary. Do you suffer or have you ever suffered from:

- Headaches or migraines? _____
- Nausea, vomiting, ringing in the ears, loss of balance, hearing loss? _____
- Sinusitis, bronchitis, pneumonia, asthma, allergies? _____
- Cardiac problems of all sorts, blood pressure problem? _____
- Diarrhea, constipation, bloating, cramps, acid reflux? _____
- Difficulty to fall asleep? No
- Do you wake up during the night? No # of times:_____, reason:_____
- When you wake up, are you tired? Do you have energy? _____
- Metabolic issues such as osteoporosis, arthritis, thyroid issues, diabetes, etc.? _____

PRESENT CONDITION

Which medication do you take? _____
What are the results of any medical investigation (X-Rays, MRI, etc.)? _____
Which sports or activities do you practice and at which frequency? _____
Dominance: Right☐ Left☐
Are you pregnant? Yes☐ No☐
What are your goals by consulting a professional here? _____

CONSENTEMENT AGREEMENT

By signing, you agree to meeting with a professional that will assess and/or treat you following her expertise.

_____	_____	_____
Signature	Date	Professional's initials