Dr. Renee Laframboise B.Sc., D.C.

Personal Information

Name: _____ Date of Birth: _____ Age: _____ Gender M / F

Address:_____

City: _____ Postal Code: _____

Home Telephone #: _____ Cell #: _____

Work#_____Email: _____

Is it okay to send you appointment reminders via email? ☐Yes ☐No

Is it okay to contact you at work? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced

Number of Children:_____

Occupation: _____Name of Business: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Medical Doctor: _____ Phone: _____

Last Physical Exam: _____

Have you had previous Chiropractic care? ☐Yes ☐No

Where? _____When? _____

Why? _____Were x-rays taken? ☐Yes ☐No

How did you hear about us? _____

Reason for your visit? ☐Health Optimization ☐Injury ☐Complaint ☐Other

Health Information:

What brings you into our office?: _____

When did you notice it? _____How often does it occur?_____

Does it radiate? ☐ Yes ☐ No If yes, where? _____

What relieves it? _____

What aggravates it? _____

Is it getting worse? ☐Yes ☐No ☐Constant ☐Comes And Goes

Are your activities of daily living being affected? ☐Yes ☐No

Is your sleep being affected? ☐Yes ☐No

Is your appetite being affected? ☐ Yes ☐ No How? _____

Has this happened before? ☐ Yes ☐ No If so, when? _____

Have you had to miss work? ☐ Yes ☐ No Last day of work:_____

Is it worse at a certain time of day? ☐ Yes ☐ No What time? _____

Is it affected by the weather? ☐ Yes ☐ No How? _____

What other healthcare professionals have you consulted for this issue?

☐None ☐Physical Therapist ☐Massage Therapist ☐Medical Doctor

How long has it been since you really felt good? _____

Past Health History:

Please check if you presently have or have had any of the following conditions in the past:

☐Blurring of Vision	☐Bronchitis	☐Diarrhea	☐Insomnia
☐Stroke	☐Asthma	☐Stomach	☐Ulcer
☐Tendonitis	☐Dizziness	☐Respiratory condition	☐Heart Burn
☐Urinary Frequency	☐High Blood Pressure	☐Chest Pains	☐Headaches
☐Lower Back Pain	☐Heart Disease	☐Diabetes	☐Allergies
☐Numbness or Tingling in Arms or Legs		☐Aneurysm	☐Hiatus Hernia
☐Sinusitis	☐Varicose Veins	☐Constipation	☐Ringing In Ears
☐Menstrual Problems	☐Osteoporosis	☐Anxiety	☐Loss of Appetite
☐Unexplained Weight Loss/Gain		☐Changes to bowel or bladder habits	
☐Poor Coordination	☐Poor Balance	☐Frequent Colds	☐Ear Infections

Family History:

Diabetes	☐ Father	☐Mother
Heart Disease	☐Father	☐Mother
Arthritis	☐Father	☐Mother
Cancer	☐Father	☐Mother
Other _____	☐Father	☐Mother

Other health problems?

_____

_____

Please check off any surgeries you have had and record the year:

☐Appendectomy_____ ☐Tonsillectomy_____ ☐Broken Bones_____

☐Gallbladder_____ ☐Hernia_____ ☐Spinal Surgery_____

☐C-Section_____ ☐Other_____

Have you recently had dental work done?_____

List of medications you now take: _____

_____

Date of last dose of antibiotics? _____

List of supplements you take (including brand if known):

_____

List and describe any auto accidents or other accidents/injuries:

_____

_____

List and describe any childhood

injuries/accidents/hospitalizations/illnesses:_____

_____

Have you been diagnosed with any concussions? ☐Yes ☐No

If yes, list the date of your last concussion_____

***Female Only**:*

Are you pregnant? ☐Yes ☐No ☐ Not sure If yes, how many weeks? _____ _

Are you breastfeeding? ☐Yes ☐No

Are you presently trying to conceive? ☐ Yes ☐ No

Are you taking birth control? ☐Yes ☐No

What was the 1st day of your last period? _____

Do you have irregular or painful periods? ☐Yes ☐No

Have you reached menopause? ☐Yes ☐No

Any pelvic conditions/surgeries (such as PCOS, endometriosis, fibroids, hysterectomy): ☐Yes ☐No

If Yes, please explain_____

Are you on HRT? ☐Yes ☐No

Lifestyle

Rate your diet: ☐Poor ☐Fair ☐Medium ☐Good ☐Excellent

Do you follow a special diet? (gluten free, vegan, Paleo, dairy free, Etc?)_____

Rate your sleep habits: ☐Poor ☐Fair ☐Medium ☐Good ☐Excellent

How often do you exercise: ☐Daily ☐3-5 Days/Week ☐1-2 Days/Week ☐Infrequent

Average length of workout ☐>30 minutes ☐30-60 Minutes ☐ <60 minutes

Types of exercise done: ☐Cardio ☐Resistance ☐Intervals ☐Yoga

How well do you cope with stress? ☐Poorly ☐Ok ☐Well

Rate your energy level: ☐Exhausted ☐Low ☐Good ☐Excellent

Do you use tobacco? ☐Yes ☐No

If Yes, Packs/day_____

Year Quit_____

Do you drink coffee? ☐Yes ☐No

If yes, how many cups/day?_____

Do you drink pop? ☐Yes ☐No

If yes, how many cans/day? _____

Anything else you feel we should know about?

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow the doctor to examine me for further evaluation. The examination may include but not be limited to a postural assessment, range of motion testing of various areas of your spine and extremities, various orthopedic and neurological tests, and a chiropractic spinal exam. which may include X-Rays and/or thermal and EMG analysis.

Patient/Parents Signature_____Date_____