Dr Gabrielle Pomerleau, D.C.
Chiropractor
91 Laval Street • Gatineau • QC • J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683
www.chirophysiogatineau.com • info@chirophysiogatineau.com

History Form

Date of consultation: ______________________________ Gender: Female ❑ Male ❑
Name: ____
Date of Birth: ( ) Day • ( ) Month • ( ) Year • **Age:**__________________
Address: ____
Town: _________________________ • Province: _________ • Postal Code: __________
Telephone • Home: ___________________ • Work: ___________________ ext.__________
Cellphone: ___________________ • E-mail: _______________________________________
❑ Yes, you may contact me via e-mail to send appointment reminders, statements and any important information regarding the clinic.
❑ **No**, I do not want to be contacted via e-mail.
Occupation: ____
Emergency contact: ____________________________ • Relationship: _________________
Emergency contact's phone number: ____

How did you hear about us?

❑ Internet ❑ Portage ❑ Doctor: ____
❑ Other Health Professional: ____
❑ Recommendation from another client: _______________________________________
❑ Other:____

Prior Chiropractic Care:

Name: ____ • Date: ______________________
X-Rays taken? ❑ Yes ❑ No • Date: ____

Medical Doctor:

Name: ____________________________________ • Telephone: _______________________
R-Rays, MRI, Ultrasound taken? ❑ Yes ❑ No • Date: _________________________________
List medications you are taking and for what conditions: ____________________________
____
Date of last medical exam: ____

What is your major complaint? ____
Other complaints? ____
How long have you had this condition?____
What do you attribute it to? ____
Does the pain travel anywhere? ____
Is it getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes
Have you had this or similar conditions in the past? ❑ Yes ❑ No
What aggravates your condition?____
What makes it better? ____
Is this condition interfering with your ❑ Work? ❑ Sleep? ❑ Daily routine? ❑ Other: ______

ChiroPhysio GATINEAU

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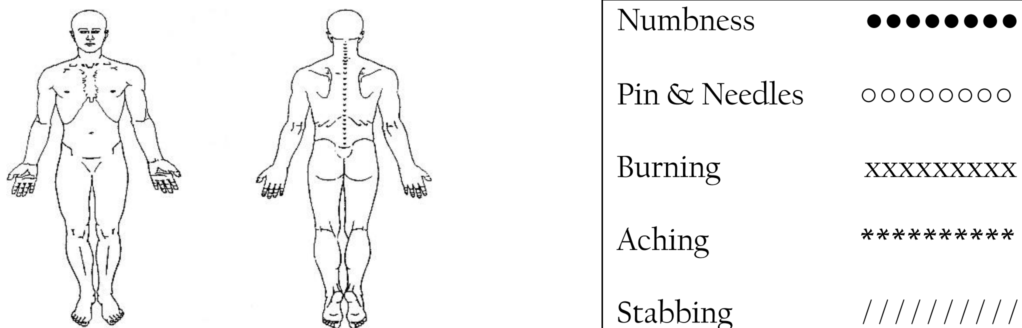
List previous diagnoses and treatments you have received for your present condition: ______
____

What do you believe is wrong with you? ____

What do you hope to do or enjoy more when you are better? ____________________________
____

Please show all area(s) of pain or unusual feeling using the appropriate symbols below.



Please draw a line on the scale to describe your pain intensity:

0 ____ 10
No Pain — The worse imaginable pain

People go to chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

❑ Relief Care ❑ Correction ❑ Wellness

Past Health History:

Please check (☑) if you have any of the following conditions.
Please circle those conditions or symptoms which have been a problem to you in the past.

❑ Head aches	❑ Dizziness	❑ Low blood pressure	❑ Kidney infection
❑ Blurred vision	❑ Numbness	❑ High blood pressure	❑ Hernia
❑ Fever	❑ Weakness	❑ Rashes	❑ Allergies
❑ Nausea	❑ Chest pain	❑ Skin condition	❑ Diabetes
❑ Vomiting	❑ Difficulty breathing	❑ Trouble urinating	❑ Fibromyalgia
❑ Loss of weight	❑ Asthma	❑ Diarrhea	❑ Cancer
❑ Sweats	❑ Chronic coughing	❑ Constipation	❑ Arthritis
❑ Heart condition	❑ Stroke	❑ Hepatitis	❑ Polio
❑ Aneurysm	❑ Osteoporosis	❑ Epilepsy	❑ HIV

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Other health problems? ____
____

List any surgery, accidents and falls, including this year:

____
____

Have you ever been in a motor car accident? ❑ Yes • Year: __________ ❑ No

Have you ever been knocked unconscious? ❑ Yes ❑ No

List any Hospitalization, including this year? ______________________________
____

Family History

Please list any medical conditions in your family: ____________________________
____
____
____

Habits of Lifestyle

Do you smoke? ❑ Yes ❑ No • Rate your sleep: ❑ Poor ❑ Fair ❑ Good
Do you exercise? ❑ Yes ❑ No • Please list: ______________________________
Do you belong to a health club? ❑ Yes ❑ No
Rate your nutrition: ❑ Poor ❑ Fair ❑ Good ❑ Excellent
Do you take vitamins and minerals? ❑ Yes ❑ No • Please list: ____________________
____

Is there anything else the doctor or health team should know?

____
____
____
____
____
____

Thank You!