Sandy Baril
Physiothérapeute
91 Laval Street • Gatineau • QC • J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683
www.chirophysiogatineau.com • info@chirophysiogatineau.com

Health Questionnaire

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: _____

Médical Doctor:

Name: _____ • Telephone: _____
X-rays, MRI, Ultrasound taken? ❑ Yes ❑ No • Date (if yes): _____
List medications you are taking and for what conditions: _____
_____
Date of last medical exam: _____

What is your major complaint? _____
Other complaint? _____
How low 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: _____
_____

Sandy Baril
Physiothérapeute
91 Laval Street • Gatineau • QC • J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683
www.chirophysiogatineau.com • info@chirophysiogatineau.com

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

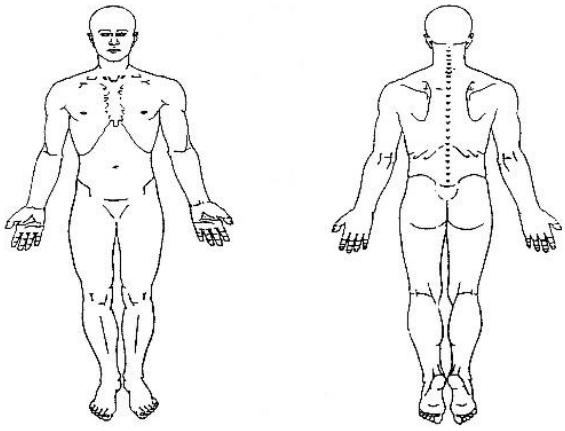
_____

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.



Numbness	●●●●●●●
Pin & Needles	○○○○○○○
Burning	xxxxxxxxx
Aching	**********
Stabbing	/ / / / / / / / / /

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

0 _____ 10

No Pain — The worse imaginable pain

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.

- ❑ Allergies
- ❑ Anxiety/Panic Attack
- ❑ Arthritis
- ❑ Asthma
- ❑ Blurred Vision
- ❑ Cancer
- ❑ Chest Pain
- ❑ Chronic Coughing
- ❑ Congestive Heart Failure
- ❑ Constipation
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Difficulty Breathing
- ❑ Dizziness
- ❑ Fever
- ❑ Headaches
- ❑ Heart Condition
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ Kidney Infection
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Nausea
- ❑ Numbness
- ❑ Rashes
- ❑ Skin Problems
- ❑ Sweats
- ❑ Trouble Urinating
- ❑ Vomiting
- ❑ Weakness

Sandy Baril
Physiothérapeute
91 Laval Street • Gatineau • QC • J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683
www.chirophysiogatineau.com • info@chirophysiogatineau.com

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: _____

_____

_____

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 we should know?

_____

_____

_____

_____

_____

_____

_____

Thank you!

Sandy Baril
Physiothérapeute
91 Laval Street • Gatineau • QC • J8X 3H4
Tel: (819) 771-8700 • Fax: (819) 771-8683
www.chirophysiogatineau.com • info@chirophysiogatineau.com

Consent

Functional Dry Needling (FDN) is a technique performed to decrease pain and restore normal functionality of your muscles. It consists of inserting acupuncture needles into " trigger points " in the muscle. No drug is injected. Before performing this technique, your physiotherapist will ensure that you are a good candidate.

Minor more common side effects of needling include bruising, numbness or tingling near the needling sites that may last a few days, temporary worsening of the symptoms and dizziness or fainting. Rare side effects include nerve damage, organ or lung puncture, and infection. While the above complications are rare in occurrence they are real and must be considered prior to treatment.

Joint Manipulations consist of a high velocity, low amplitude thrust on a bone to allow motion of a joint. It is a safe and effective method to reinstate motion in a joint and reduce the pain in your muscles in the surrounding area. There is often a " POP " or " CLICK "that may occur, this is simply air pressure releasing. Your physiotherapist will determine whether you are a suitable candidate for manipulation before this technique is performed. This decision will be guided by the results of your physical examination and knowledge of your relevant health history.

Mild temporary side effects can occur with joint manipulations. These include, but are not limited to, local discomfort, numbness, dizziness, and/or headaches. More serious side effects are much less frequent but can occur. These include, but are not limited to, worsening of symptoms, nerve or disk injury, fracture, and rarely, with neck manipulation, stroke and death. Estimates of the risk of serious side effects from a neck manipulation vary widely, 1/50 000 to 1/5.85 million, but the risk appears " smaller than that associated with many commonly used diagnostic tests or prescription drugs. "

Acupuncture/FDN/Joint manipulation may not be appropriate if you:

___ are pregnant
___ have experienced syncope (fainting)
___ have a collagen disorder
___ have a deficient bone density
___ have a pacemaker or a heart condition
___ have diabetes or a clotting disorder
___ have a fear of needles or have ever had a reaction to needles
___ have ligament laxity
___ are on blood thinners such as Coumadin, Warfarin, Heparin, Plavix or high doses of Aspirin

By signing/initialing below I am indicating that I have read, or have had read to me, and understand this consent to treatment, and have had an opportunity to ask questions. I have considered the benefits and risks of treatment as well as understand the nature of the treatment to be provided to me. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment. I understand that I may withdraw my consent at any time.

ACUPUNCTURE Initials: _____ • Date (Y/M/D): _____
FUNCTIONAL DRY NEEDLING Initials: _____ • Date (Y/M/D): _____
JOINT MANIPULATION Initials: _____ • Date (Y/M/D): _____

_____ _____
Signature of patient Date (year/month/date)