



It's Your First Visit—Welcome!

When you arrive at our office you will be greeted warmly by our staff, who are exceptionally well trained and were hand-picked for their commitment to customer service. Their first priority is to help you have a comfortable experience. They will answer your questions and explain our fee structure.

Soon after arriving, you will have a private meeting with Dr. Groulx to discuss your health concerns. There is no doubt you will find Dr. Groulx to be warm, personable, a "straight-shooter" and a great listener. He is also a top-notch chiropractor who counts several chiropractors from the Ottawa area among his client base. People have traveled from as far away as South Korea and Baffin Island for his expertise.

If yours is a chiropractic case, Dr. Groulx will proceed with detailed "hands-on" chiropractic examination. Every step will be explained and will be done with your consent. Depending on the results of these preliminary tests Dr. Groulx may recommend x-rays which will be accomplished in our on-site x-ray suite. With the initial examination completed, your first visit will come to an end. **Plan for approximately 40 minutes for your first visit.**

At the end of your first visit you will be invited to return for your report of findings (your second visit). This report is designed to explain the results from your first visit. Feel free to invite your spouse or significant other to this visit.

Please take the time to carefully complete the initial paperwork on pages 2—3 of this document before you arrive.



CONFIDENTIAL CASE HISTORY

Your answers will help us determine if our care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

DATE: _____

PERSONAL INFORMATION

Name: _____

E-MAIL: _____

How do you wish to be addressed in our office? First Name Mr. Mrs. Ms Miss Dr.

Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Business _____

Date of Birth: yy__mm__dd____ Cell Phone _____

Employer: _____ Address: _____

Occupation: _____

Spouse/Partner's Name: _____ How many children do you have? (Age and Gender)

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

How did you hear about us? If it was "Google", tell us what you typed as a search term. _____

OTHER PROVIDERS

Have you consulted a chiropractor previously? Y N Chiropractor's Name: _____

When was your last visit? _____ What was the problem? _____

Was the experience a good one? Yes No

Family Doctor's Name: _____ Address: _____ Tel: _____

May we send progress notes to your family doctor? No Yes your initials here if "yes"

REASON FOR CONSULTING OUR OFFICE

Stress Symptoms

- Headache/Migraine
- Dizzy
- Ringing in ears
- Blurring of vision
- Poor concentration
- Loss of sleep
- Depression
- Decreased energy
- Irritability

Muscle/Joint/Bone

- Backache
- Neck pain
- Arm/hand pain or tingling
- Leg/foot pain or tingling
- Tension/pain in shoulders
- Scoliosis
- Osteoporosis
- Osteoarthritis

Digestive

- Gall bladder pain
- Heartburn
- Constipation
- Loose stool
- Stomach pains

Neurological

- Seizures
- Fainting
- Convulsions
- Loss of balance
- Vertigo
- Tremors

Ears Nose Throat

- Earache
- Sinus trouble
- Chronic runny nose
- Allergies
- I am a smoker
- Cancer in my history
- Cancer in my family

Cardiorespiratory

- Asthma
- Chest pain
- COPD
- Emphysema
- Chronic cough
- Heart palpitations
- Racing heart
- High blood pressure
- Stroke / Heart attack

Genitourinary

- Painful voiding of bladder
- Blood in urine
- Urgency
- Enlarged prostate

Females Only!

- Painful menses
- Irregular menses
- Fibroids

List any prescription drugs you are taking. _____

Are you pregnant? Circle one. Yes No

I hereby consent to a hands-on physical examination. I also certify that the information I have provided is true and complete.

Patient Signature: _____ **Date:** _____

Name: _____

1. Pain Intensity

No pain Mild pain Moderate pain Worst possible

2. Sleeping

Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep

3. Personal Care (washing, dressing, etc)

No pain, no restrictions Mild pain but no restrictions Moderate pain: moving slowly Moderate pain: need some assistance Severe pain: need 100% assistance

4. Travel (driving , riding bus etc.)

No pain on long trips. Mild pain on long trips. Moderate pain on long trips Moderate pain on short trips. Severe pain on short trips.

5. Work

Can do usual work plus unlimited extra work. Can do usual work but no extra work Can do 50% of usual work Can do 25% of usual work Cannot work

6. Recreation

No pain Mild pain Moderate pain Worst possible

7. Frequency of Pain

No pain Occasional pain: 25% of day Intermittent pain: 50% of day Frequent pain: 75% of day Constant pain 100% of day

8. Lifting

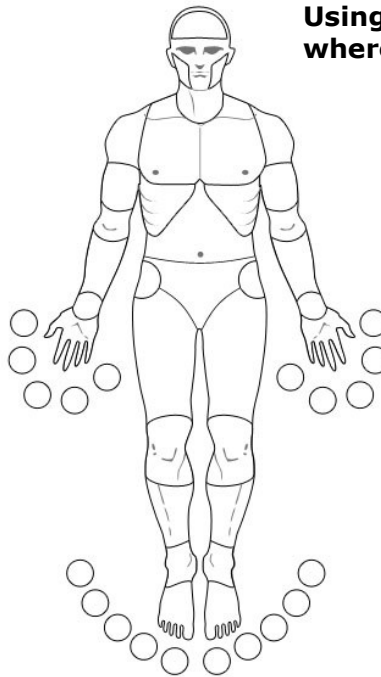
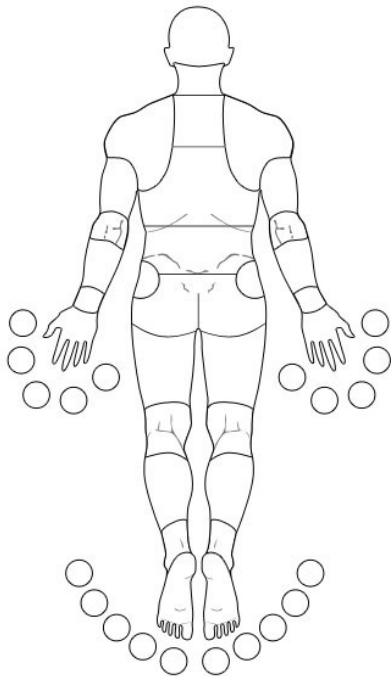
No pain w/ heavy weight Increased pain w/ heavy weight Increased pain w/ moderate weight Increased pain w/ light weight Increased pain w/ any weight

9. Walking

No pain any distance Increased pain after 1 km Increased pain after 1/2 km Increased pain after 250m Increased pain all walking

10. Standing

No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 30 min Increased pain w/ any standing



Using a pen, carefully show us where your symptoms are.

Survey Question: You prefer Tim Horton's Starbucks Not a coffee drinker....I know, it's a random question.