



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 help you fill out the initial paperwork, answer your questions and explain our fee structure.

Soon after you have filled out the initial paperwork, 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 an orthopedic, neurological and 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. **Budget 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.**



**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? Doctor'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

**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**

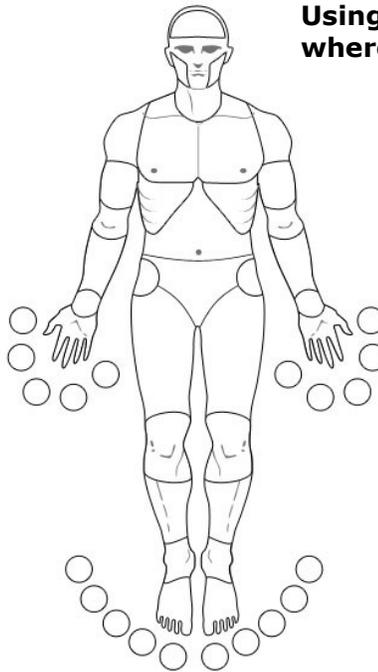
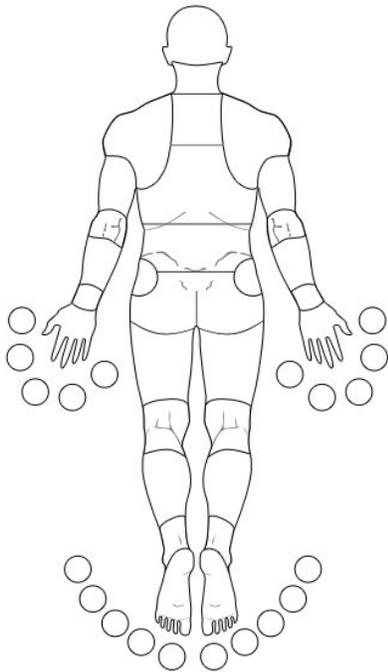
No pain w/ heavy weight    Increased pain w/ heavy weight    Increased pain w/ moderate weight    Increased pain w/ light weight    Increased pain w/ any weight

**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.