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Health Form

Name:		Date:	
Address:		City:	Prov: Postal code
Birth date:	Occupation	Status:	Children:
Home phone:	Work: ext:	other:	e-mail address:
Who did refer you to our office?			

Please complete the following questions in order to help you to participate in a care program specifically centered on your nervous system, your health and your wellness.

Part 1: Your health concerns and symptoms and how they may affect your life

Do you have any current health concerns? If so please describe. If not, go to section 2	
When did this situation or concern begin:	
Did you consult any other professional regarding this condition? No <input type="checkbox"/> Yes <input type="checkbox"/>	Which Professional?
If yes, what were you told?	
What was done?	
What had been the results?	
Why do you think this has happened or continues to happen to you?	
It is the solo cause? What other factor could be implied:	
What are you doing in your life now that is different because of this condition/symptom	
Is there any time, or any activity you can be involved with when you totally or almost total forget about this condition, symptom or concern? If yes please explain	
Is there any time or activity that makes you more aware of your condition, symptom or concern?	
Grade in order the 3 life domains that are the most impaired from your health concern.	
_____ Work, School _____ Sports, Hobbies _____ Relations, Family	_____ Sitting, Walking _____ Sleep, Rest
What best describes your current relation or feeling about yourself and your situation	
<input type="checkbox"/> Like if nothing can help me, I am scared and I worth more than what is happenin <input type="checkbox"/> I feel stuck and I don't know what to do next <input type="checkbox"/> My symptoms only harm me and I need to get rid of therr <input type="checkbox"/> I would like that you assist me in my healing or wellness process <input type="checkbox"/> My symptoms is a key resource in my healing and wellness process	
Define what is a treatment that work	

Part 2: Health, Trauma, Medical, Chiropractic and Healing history

Have you ever injured your spine(neck, head, back, hips)?

- a) Date of most significant injury
- b) What happened?

- c) Date of most recent injury?
- d) What happened?

- e) Have you broken any bones or significantly sprained any part of your body? If yes explain

- f) Date of the most important car accident:
- g) Describe :

Have you consulted a physician, or any other health care provider in the past 3 months
When was your last visit? Why?

What was done or suggested?

Have you ever had any spinal X-rays, Cat scans or MRI imaging of your spine, head, neck, back or hips
What were you told about these exams?

Have you had any operations or surgeries? When and Why?

Do you take medications? Which one?

Please list any herbs, vitamins or natural products you take regularly

If you have had experience with the following health or treatment modalities please check and describe when you went, for how long, and what the results were

- Massage / body work
- Physiotherapy / ergotherapy
- Osteopathy
- Chiropractor
- Network Spinal Analysis (NSA)
- Tai Chi, Chi gong, yoga
- Nutritionist
- Psychotherapy
- music / dance / sound / light / aromatherapy
- Ayurvedic medicine
- Chinese medicine/acupuncture
- Homeopathy
- Total biology
- Other _____

What sport or physical activities do you practice regularly?

Do you have a particular nutritional diet?

What is your favorite hobby?

Do you have any otherway to deal with stress?

Part 3 : Care benefits

What made you consult now!

At what crossroad in life are you at right now?

What are your options, way or possibilities?

What actions are you willing to take right now to improve and create change in your life

What in life do you feel called for, that you have neither the motivation or courage to do

Patients under our care have benefits on all the following levels of their health and wellness
 Which are the 3 benefits in order of importance that you would love to get out of our care?

Improvement of my physical symptoms
 Improvement of emotional / mental symptoms
 Improvement of my ability to react or respond to stress
 Ability to make more constructive choices
 Overall improved quality of life
 Improvement in the enjoyment of life

How could we help you the most?

What would motivate you to share about the care you will receive here?

Part 3: Stress Survey

Check the following stresses as they apply to you and grade their severity

Physical stress / trauma

	absent	moderate	severe
Birth trauma			
Sports injuries			
Work related			
Posture stress			
Dental			
Physical abuse			

Other :

Stored emotional stress

	absent	moderate	severe
Birth trauma			
School			
Family			
Work related			
Change of career			
Financial			
Divorce / separation			
Parental divorce			
Change of lifestyle - moving			
Loss of a loved one			
Physical abuse			
Sexual abuse			
Emotional abuse			
eating disorders			
Accident or illness			
Hospitalization or surgery			

Stress chimique / intoxication accumulée

At what frequency do you consume:

	Aucun	1x/month	1x per week	1x per day	is to much?
Drugs (recreational/prescription)					
Alcohol					
Tobacco					
Soft Drink					
Caffeine					
Tap Water					
Refined sugar					
Artificial sweetners					
Restauration rapide "fast food"					
Had you been vaccinated?	Yes <input type="checkbox"/> / No <input type="checkbox"/>		How many ?		