



Dr Simon Tanguay DC
 2228 St-Antoine Ouest
 Montréal, Québec, H3J 1A7
 Près du Métro 📍 Georges-Vanier
expressiondevie@simontanguay.com

514 667-3911

Health Questionnaire

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

Please complete those following questions in order to help you participate in a wellness-treatment program specifically focus on your nervous system, your health and your well-being.

Part 1: How your health concerns and symptoms may affect your life

<p>Do you have any current health concerns? If so please describe. <i>If not, go to section 2</i></p> <p>When did this situation or concern begin?</p>						
<p>Have you consulted any other professional regarding this condition/symptom? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>If yes, what were you told? Which Professional?</p> <p>What was done? What were the results?</p>						
<p>What caused this to happen? Why is it still happening?</p> <p>Is this the only cause? What other factors could be involved?</p> <p>How has you life changed because of this condition/symptom?</p> <p>Is there any circumstance, or any activity you that you engage in that has you totally or almost totally forget about this condition, symptom or concern? If yes please explain.</p> <p>Is there any circumstance or activity that aggravates your condition, symptom or concern?</p>						
<p>Categorize the 3 domains of your life that have been negatively influenced from your health condition/symptom.</p> <table style="width: 100%;"> <tr> <td>___ Work, School</td> <td>___ Sitting, Walking</td> </tr> <tr> <td>___ Sports, Hobbies</td> <td>___ Sleep, Rest</td> </tr> <tr> <td>___ Relationships, Family</td> <td></td> </tr> </table>	___ Work, School	___ Sitting, Walking	___ Sports, Hobbies	___ Sleep, Rest	___ Relationships, Family	
___ Work, School	___ Sitting, Walking					
___ Sports, Hobbies	___ Sleep, Rest					
___ Relationships, Family						
<p>What best describes your current relationship or feelings about yourself and your condition/symptom?</p> <p><input type="checkbox"/> Nothing can help me I am scared</p> <p><input type="checkbox"/> I am worth more than what is happening</p> <p><input type="checkbox"/> I feel stuck and I don't know what to do next.</p> <p><input type="checkbox"/> My symptoms only harm me and I need to get rid of them</p> <p><input type="checkbox"/> I would like you to assist me in my healing or wellness process</p> <p><input type="checkbox"/> My symptoms are messengers or resources in my healing and wellness process</p>						
<p>Define what is a treatment that works</p>						

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

<p>Have you ever injured your spine(neck, head, back, hips)?</p> <p>a) Date of most serious injury</p> <p>b) What happened?</p> <p>c) Date of most recent injury?</p> <p>d) What happened?</p> <p>e) Have you broken any bones or significantly sprained any part of your body? If yes explain:</p> <p>f) Date of the most traumatic car accident:</p> <p>g) Describe what happened:</p>																																																												
<p>Have you consulted a physician, or any other health care provider in the past 3 months?</p> <p>When was your last visit? Why?</p> <p>What was done or suggested?</p> <p>Have you ever had spinal X-rays, CAT scans or MRI's of your spine, head, neck, back or hips?</p> <p>List all operations or surgeries? When? Why?</p> <p>What medications do you take?</p> <p>Please list any herbs, vitamins or natural products you take regularly.</p>																																																												
<p>If you had experience with the following health or treatment modalities pl check one</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 15%; text-align: center;">When?</th> <th style="width: 15%; text-align: center;">How Long?</th> <th style="width: 10%; text-align: center;">Results!</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Massage / body work</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Physiotherapy / ergotherapy</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Osteopathy</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chiropractor</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Network Spinal Analysis (NSA)</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tai Chi, Chi gong, yoga</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Nutritionist</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Psychotherapy</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> music / dance / sound / light / aromatherapy</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Ayurvedic medicine</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chinese medicine/acupuncture</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Homeopathy</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Total biology</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		When?	How Long?	Results!	<input type="checkbox"/> Massage / body work				<input type="checkbox"/> Physiotherapy / ergotherapy				<input type="checkbox"/> Osteopathy				<input type="checkbox"/> Chiropractor				<input type="checkbox"/> Network Spinal Analysis (NSA)				<input type="checkbox"/> Tai Chi, Chi gong, yoga				<input type="checkbox"/> Nutritionist				<input type="checkbox"/> Psychotherapy				<input type="checkbox"/> music / dance / sound / light / aromatherapy				<input type="checkbox"/> Ayurvedic medicine				<input type="checkbox"/> Chinese medicine/acupuncture				<input type="checkbox"/> Homeopathy				<input type="checkbox"/> Total biology				<input type="checkbox"/> Other _____			
	When?	How Long?	Results!																																																									
<input type="checkbox"/> Massage / body work																																																												
<input type="checkbox"/> Physiotherapy / ergotherapy																																																												
<input type="checkbox"/> Osteopathy																																																												
<input type="checkbox"/> Chiropractor																																																												
<input type="checkbox"/> Network Spinal Analysis (NSA)																																																												
<input type="checkbox"/> Tai Chi, Chi gong, yoga																																																												
<input type="checkbox"/> Nutritionist																																																												
<input type="checkbox"/> Psychotherapy																																																												
<input type="checkbox"/> music / dance / sound / light / aromatherapy																																																												
<input type="checkbox"/> Ayurvedic medicine																																																												
<input type="checkbox"/> Chinese medicine/acupuncture																																																												
<input type="checkbox"/> Homeopathy																																																												
<input type="checkbox"/> Total biology																																																												
<input type="checkbox"/> Other _____																																																												
<p>What sports or physical activities do you practice regularly?</p> <p>Do you follow a particular nutritional or dietary routine?</p> <p>What is your favorite hobby?</p> <p>How do you deal with stress?</p>																																																												

Part 3 : Care benefits

What motivated you to come for a consultation today?

What crossroad in life are you at right now?

What are different paths you can take?

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

What are you passionate about and have been afraid to act on?

Patients have repeatedly reported improved levels of health and wellness in the following areas:
 Pick 3 benefits, in order of importance, that you would love to get out of our care?

Improved physical symptoms
 Improved emotional / mental symptoms
 Improved ability to react or respond to stress
 Overall improved quality of life
 Improvement in the enjoyment of life

How could we help you the most?

Part 3: Stress Survey

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

Physical stress / trauma	None	moderate	severe
Birth trauma			
Sports injuries			
Work related			
Posture stress			
Dental			
Physical abuse			

Other :

Stored emotional stress	None	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			

Chemical Stress

<i>What amount do you consume?</i>	None	1x/month	1x per week	1x per day	too much?
Drugs (recreational/prescription)					
Alcohol					
Tobacco					
Soft Drink					
Caffeine					
Tap Water					
Refined sugar					
Artificial sweetners					
Restaurant "fast food"					
Have you been vaccinated?	Yes <input type="checkbox"/> / No <input type="checkbox"/>		How many ?		