Nom:
Age:
Address:
Profession:
telephone:

Reason of consultation:

.Where does it hurt?
.Can you describe the pain and the level of this pain? Constant, sharp, burning...
.Is there a daily pattern to the pain? worse at night, stiff in the morning..
. What aggravates the pain?
. What relieves the pain?
. When did it happen? And what were you doing?
. Have you consulted any other healthcare professional regarding your injury?
. What is your opinion of the problem?
. Have you any previous history of this injury and how often has it reoccurred in the past?

Other medical history.

. Past surgeries, Fractures, sprains...
. Other hospitalisations:
. Medication past or present:

Other information (that may be seemingly irrelevant yet could well be important)

. family medical history
. Do you smoke or drink?
. Do you do sports?
. Do you sleep well?
. Allergies or food intolerances
. Dental history
. Migraines, vertigo,
. Recurrent infections
. Any Respiratory, cardio-vascular, digestive, uro-genital dysfunction?