Patient Intake Form

Personal Information

Date: _____ #_____

Name: _____ Home #: _____

Address: _____ Work #: _____

City: _____ Prov: _____ Postal Code: _____

Occupation: _____ Age: _____ Date of birth: D M Y _____

M/F _____ # of Children: _____ Extended health coverage: _____

Emergency contact: _____ Phone # _____

E-Mail Address: _____ Employer: _____

How did you hear about our office? Phonebook ☐ Sign ☐ Radio ☐ Internet ☐ Newspaper ☐ Tradeshow ☐

Friend: _____ Other: _____

Previous Chiropractic Care

Name: _____ Date of last visit _____ # of visits: _____

Medical Doctor

Name: _____ Date of last visit _____ Reason: _____

Date of last physical: _____ Phone #: _____

Chiropractic Health Information

Primary reason for consulting our office : _____

When did it start? _____ Have you had a similar condition in the past ? Yes ☐ No ☐ When _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes & goes ☐

What aggravates your condition ? _____

Have you consulted other health care practitioners for this complaint ? Yes ☐ No ☐

Please list: _____

Do you have any other health complaints ? _____

Special Tests: CT Scan ☐ MRI ☐ Ultrasound ☐ X-Rays ☐

Patient Name: **Date:** **#:**

Symptom Diagram

In the diagram provided, please mark the areas on your body which you feel best represent the pain (s) or sensations you are experiencing . Include all affected areas . Use the appropriate symbols :

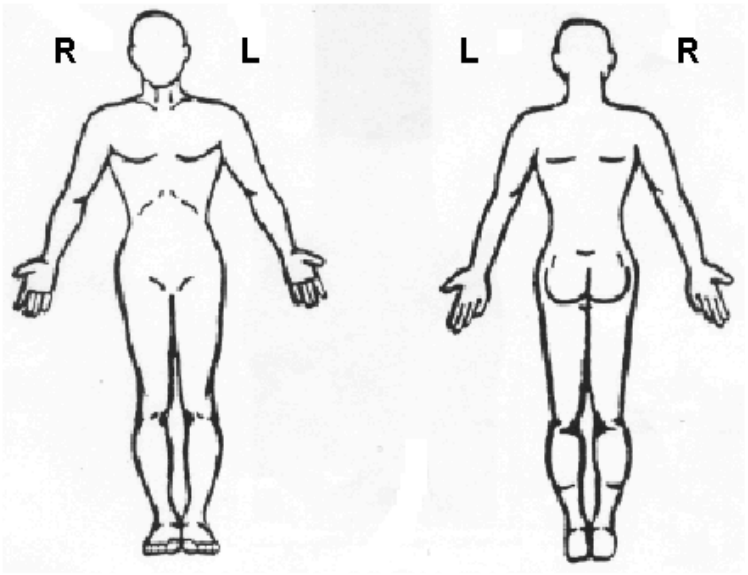
Numbness . . . . . / . . . . . / . . . . .

Pins& Needles o o o o o o / o o o o o o / o o o o o o

Burning x x x x x / x x x x x / x x x x x

Aching * * * * * / * * * * * / * * * * *

Stabbing / / / / / / / / / / / / / / /



Front **Back**

Rate the severity of your pain by checking one box on the following scale :

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

Mild - annoying Moderate - uncomfortable Severe - horrible

Please list any surgeries or major illnesses you have had and when :

Surgery or illnesses : Year

Do you wear orthotics in your shoes ? Yes ☐ No ☐

Please list current medications :

Please list vitamins, minerals or supplements :

Is your current condition the result of : recent motor vehicle accident ☐ a work related accident ☐

Have you ever been in a motor vehicle accident or had any other personal injury or accident ? Yes ☐ No ☐

Please describe :

Do you smoke? Yes ☐ No ☐ If no, have you smoked in the past? Yes ☐ No ☐

How many cups of coffee/tea do you consume daily ? ☐ pop ☐ Do you consider the stress in your life to be: Mild ☐ Moderate ☐ High ☐

Are you interested in receiving Chiropractic care ? Yes ☐ No ☐ and/or Acupuncture ? Yes ☐ No ☐

and/or Laser Therapy ? Yes ☐ No ☐

Patient Name _____ Date_____ #_____

HEALTH SURVEY

*Please check(√) any areas which have been a concern to you **in the past**. Please circle any **current concerns**.*

GENERAL SYMPTOMS

- ☐ Headache
- ☐ Fever
- ☐ Fainting
- ☐ Sweats
- ☐ Dizziness
- ☐ Convulsions/Seizures
- ☐ Loss of sleep
- ☐ Fatigue/Low Energy
- ☐ Nervousness
- ☐ Confusion
- ☐ Depression
- ☐ Skin Problems
- ☐ Anxiety

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Pain or numbness in:
  - ☐ Arms
  - ☐ Hands
  - ☐ Legs
  - ☐ Feet
- ☐ Back pain
- ☐ Swollen joints
- ☐ Sore muscles
- ☐ Walking problems
- ☐ Ruptures
- ☐ Broken bones
- ☐ Painful / noisy jaw

CARDIO-VASCULAR

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Angina
- ☐ Difficult breathing
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lung problems
- ☐ Varicose veins

GENITO-URINARY

- ☐ Bladder trouble
- ☐ Prostate trouble
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Kidney infection
- ☐ Bedwetting

FEMALE

- ☐ Painful menstruation
- ☐ Cramps or backache
- ☐ Unusual bleeding
- ☐ Menopausal symptoms
- ☐ Lumps on breast
- ☐ Is there a possibility you might be pregnant ?
- ☐ Are you pregnant ?

Due date_____

GASTRO-INTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/indigestion/ulcer
- ☐ Weight gain/loss
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Black or bloody stool
- ☐ Constipation
- ☐ Gall Bladder
- ☐ Liver trouble

E.E.N.T.

- ☐ Eye problems
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Ear problems
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Nose problems
- ☐ Dental problems
- ☐ Sinus problems /infection
- ☐ Frequent colds
- ☐ Difficult swallowing
- ☐ Difficult speech

Have you ever had any of the following :

- ☐ aneurysm or stroke
- ☐ respiratory conditions
- ☐ allergies
- ☐ asthma
- ☐ HIV
- ☐ AIDS
- ☐ osteopenia
- ☐ osteoporosis
- ☐ epilepsy
- ☐ heart attack
- ☐ polio
- ☐ psoriasis
- ☐ diabetes
- ☐ cancer
- ☐ hepatitis
- ☐ STD
- ☐ arthritis
- ☐ heart disease
- ☐ tuberculosis
- ☐ haemophilia
- ☐ blood disorder
- ☐ multiple sclerosis

Significant health concerns of blood relatives _____

Do you have: ☐ pace maker ☐ joint replacement ☐ surgical pins or clips