

INTAKE FORM

Name: _____ **Phone:** (home) _____

Birthdate: _____ (month/day/year) (cell) _____

Address: _____ **Email:** _____

Postal Code: _____ I would like: email reminders

text message reminders

Occupation: _____ phone call reminders

How did you hear about us? Friend: _____ Website Facebook

Other professional: _____ Other: _____

Extended Benefits Provider: _____ ICBC or WCB Claim? Yes No

Care Card #: _____ Claim #: _____

CURRENT CONDITION:

What brings you into the office today?

When did it start? _____

Is it getting?: Better Worse

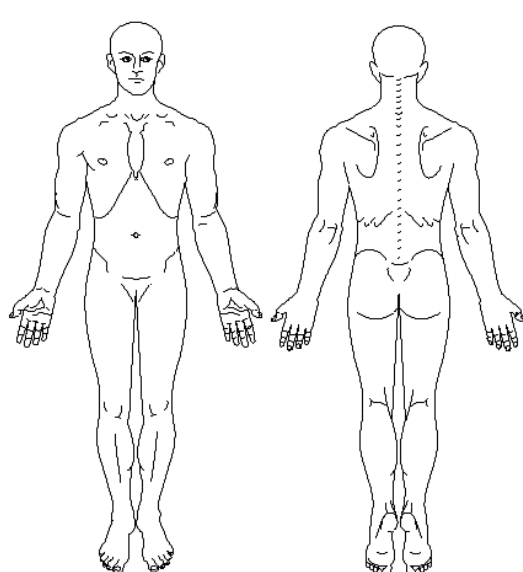
Have you had this before?: Yes No

When? _____

List any other professionals seen for this:

PAIN DRAWING

SHADE IN WITH A PEN ALL AREAS YOU HAVE PAIN.
(Don't forget to include the head or areas of lesser pain).
Use small x's to show any areas of numbness or tingling



When do your symptoms affect you the most? _____

Are you currently taking any medication or supplements?: Please list: _____

Do you have any allergies?: _____

What are your goals for treatment?: _____

HEALTH HISTORY AND INFORMATION:

Please check any conditions/symptoms that apply to you:

GENERAL CURRENT CONDITIONS

- Recent accident** such as a fall, whiplash, or blow to the head
- Spinal/back/neck problems
- Muscle spasms
- Restricted movement
- Numbness or tingling of hands or feet or radiating pain
- Headaches or Migraines
- Sinus problems
- Nausea
- Depression
- Anxiety or difficulty with stress
- Dizziness or vertigo
- Vision problem
- Hearing problem
- Sleeping trouble
- Asthma or breathing problem
- Digestive trouble
- Heartburn/Acid Reflux
- Menstrual problems
- Jaw or mouth problem
- Arm, shoulder, elbow or hand problem
- Leg, hip, knee or foot problem

SPECIFIC PAIN IN THE BODY

- Difficulty swallowing because of neck pain
- Pain or electric shocks in arms or legs when moving neck
- Leg pain worse with exercise
- Numbness of inner thighs
- Back pain with urinary problems
- Severe pain that interrupts sleep
- Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- Poor balance
- Loss of bowel or bladder control
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Memory loss after injury
- Recent, unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or current fever over 102°F

Have you ever been diagnosed with a medical condition? (describe) _____

Please describe any serious trauma/ accidents/ injuries/ surgeries/ hospitalizations? _____

Have you ever had any other health concerns? (describe): _____

Have you had chiropractic care before: Yes No _____

Are you exercising or performing any physical activities? _____

How would you describe your sleep habits? _____

How would you describe your diet? _____

Are you currently pregnant? Yes No Women's health concerns? Yes No

Have you ever had an X-ray of your spine? Yes No _____

Are you currently under the care of any other type of health practitioner? _____

Date last seen? _____ Medical Doctors Name: _____

Any other concerns or issues we should be aware of?: _____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 12 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and I give the clinic permission to leave messages regarding appointments at any of the contacts I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____