NUVISTA
CHIROPRACTIC AND WELLNESS

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Penticton, BC, V2Y 5Y5
www.nuvistachiropractic.com

INTAKE FORM

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

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

Address: _____ **Email:** _____

Postal Code: _____ I would like: ☐ email reminders
☐ text message reminders
☐ phone call reminders

Occupation: _____

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? _____

_____

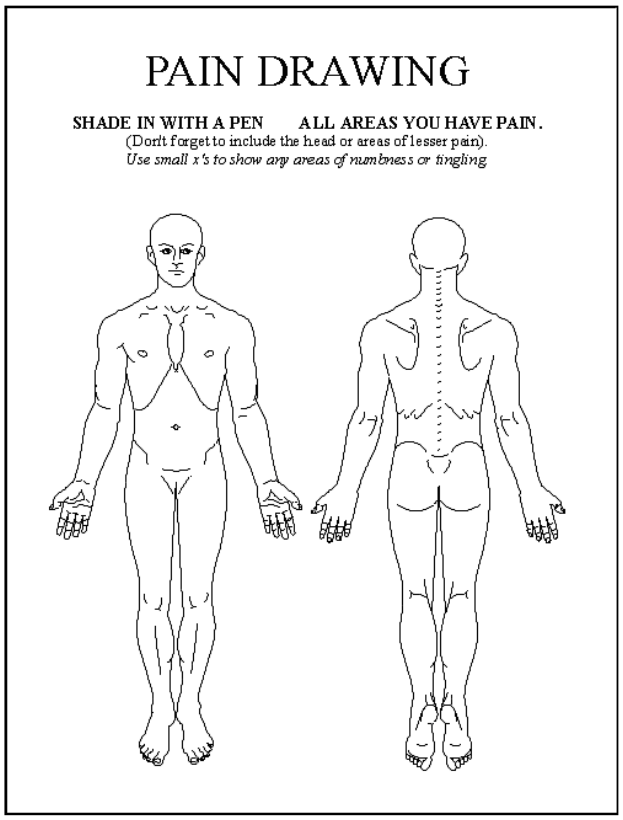
Is it getting?: ☐ Better ☐ Worse

Have you had this before?: ☐ Yes ☐ No

When? _____

List any other professionals seen for this:

_____



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?:_____

CURRENT PREGNANCY:

How far along are you in your pregnancy? _____ Due Date? _____

Have you experienced issues with fertility or miscarriage? ☐ Yes ☐ No

Childbirth caregivers (circle): OB/GYN Midwife Doula: _____

Last visit with caregiver: _____ Any concerns?:_____

Are you planning on having your baby: ☐ In hospital ☐ At home ☐ Other: _____

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

_____

Have you ever, or have you currently experienced any of the following during pregnancy?:

☐falls/trauma ☐ MVA ☐ high blood pressure ☐ diabetes ☐ anemia ☐ seizures ☐ heart problems ☐ back/hip/groin pain ☐ abnormal bleeding ☐ hospitalizations ☐ trouble sleeping ☐ headaches/neck pains

☐ any other illness or concerns (describe): _____

Are you currently exercising or doing any other activities?: _____

Are you currently working?:_____

PREVIOUS PREGNANCIES:

How many pregnancies have you previously had?: _____

Did you experience any complications during the delivery?:_____

Any emergency care needed? _____

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? _____

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 benificial 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: _____