CHIROPRACTIC PATIENT INTAKE FORM

PERSONAL INFORMATION

TITLE: MR.☐ MRS.☐ MISS.☐ MS.☐ DR.☐				DATE:
FIRST NAME	INITIAL	LAST NAME		HEIGHT : WEIGHT:
ADDRESS	APT #	CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE	CELL NUMBER	OTHER	EMAIL ADDRESS	
BIRTH DATE DAY/MONTH/YEAR	Sex Assignment at Birth ☐ MALE ☐ FEMALE		**HOW DID YOU HEAR ABOUT US?**	

IN CASE OF EMERGENCY

CONTACT NAME	TELEPHONE	RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ YES ☐ NO

DOCTOR'S NAME	DOCTOR'S TELEPHONE NUMBER	LAST VISIT

DO YOU HAVE ANY ALLERGIES?	ARE YOU MAKING A CLAIM FOR 1) RECENT MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO 2) WORK RELATED INJURY/ACCIDENT (WSIB) ☐ YES ☐ NO

CHIROPRACTIC INFORMATION

REASON FOR SEEKING CHIROPRACTIC CARE TODAY?	HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?

HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFFESSIONAL? ☐ YES ☐ NO

TREATMENT RECEIVED

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO *IF YES PLEASE COMPLETE THE FOLLOWING:*

CHIROPRACTOR'S NAME	LAST VISIT
REASON FOR SEEKING CARE	RESULTS ☐ GOOD ☐ FAIR ☐ POOR

HEALTH INSURANCE

DO YOU HAVE PRIVATE HEALTH INSURANCE THROUGH A MEDICAL PLAN? ☐ NO Spouse/Parent D.O.B:

☐ YES; MY OWN PLAN	☐ YES; MY SPOUSE'S PLAN	☐ YES; MY PARENTS PLAN
COMPANY ________________________	COMPANY ________________________	COMPANY ________________________
PLAN/POLICY # ____________________	PLAN/POLICY # ____________________	PLAN/POLICY # ____________________
ID/CER/EMP # _____________________	ID/CER/EMP # _____________________	ID/CER/EMP # _____________________

Please check "√" if you are experiencing the following symptoms. Please check all that apply.

General:
- Loss of Consciousness ☐
- Blackouts ☐
- Loss of sleep ☐
- Fever ☐
- Nervousness ☐
- Weight loss ☐
- Excess sweating ☐
- Night Sweats ☐
- Night pain ☐
- Generalized pain ☐
- Headaches ☐
- Convulsions ☐

Neurologic:
- Dizziness ☐
- Fainting ☐
- Blurred Vision ☐
- Double Vision ☐
- Nausea ☐
- Clumsiness ☐
- Numbness & tingling ☐

Muscles and Joints:
- Sore/stiff neck ☐
- Mid back ache ☐
- Low back ache ☐
- Painful tailbone ☐
- Shoulder pain ☐
- Upper limb pain ☐
- Hip pain ☐
- Knee pain ☐
- Ankle/foot trouble ☐
- Arthritis ☐
- Loss of strength ☐

Respiratory:
- Asthma ☐
- Chronic cough ☐
- Difficulty breathing ☐
- Spitting up phlegm/blood ☐

Genitourinary:
- Trouble urinating ☐
- Blood in urine ☐
- Kidney infection ☐
- Bedwetting ☐
- Prostate trouble ☐

Cardiovascular:
- Bleeding disorder ☐
- High blood pressure ☐
- Chest pain ☐
- Stroke ☐
- Hardening of arteries ☐
- Varicose veins ☐
- Swelling of ankles ☐
- Poor circulation ☐
- Heart/blood disease ☐
- Angina ☐

Gastrointestinal:
- Poor appetite ☐
- Indigestion ☐
- Excess hunger ☐
- Belching or gas ☐
- Vomiting ☐
- Pain over stomach ☐
- Constipation ☐
- Diarrhea ☐
- Hemorroids ☐
- Jaundice ☐
- Gallbladder trouble ☐

GU for women:
- Menstruation issues ☐
- Breast swelling/lump ☐
- Hot flashes ☐
- Vaginal discharge ☐

Family history:
Cancer ☐ Diabetes ☐ Hypertension ☐ Stroke ☐

Lifestyle:
- Smoking ☐ If so, how much?
- Alcohol ☐ If so, how much?
- Exercise ☐ If so, how often?
- Healthy diet ☐

List all past surgeries:

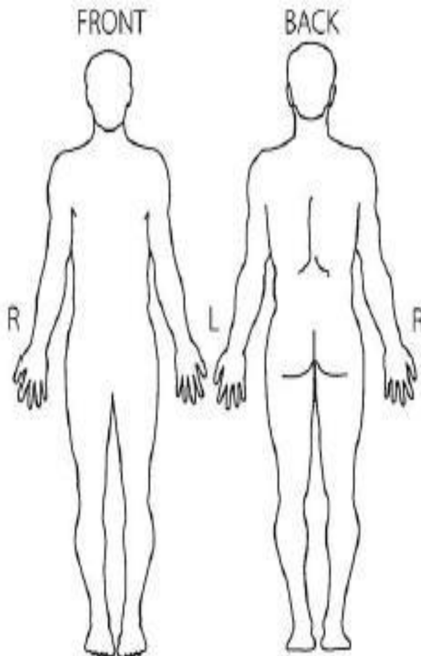
Have you had any **past fractures**? ☐ Yes ☐ No
If yes, where?

Have you ever been diagnosed with:
Cancer ☐ HIV/AIDS ☐ Hep A/B/C ☐

List all prescription/over-the-counter **medications** and **supplements** you are presently taking:

Women only: Are you Pregnant? ☐ Yes ☐ No
Due Date:

CHIEF COMPLAINT



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

1

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	+++++	^^^^^^^	*****	///////////	====

2

How did your symptoms start?
- ☐ Sudden
- ☐ Gradual
- ☐ Car accident
- ☐ Work related injury

When did your symptoms start?
- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

3

Please mark on the line below the level or your discomfort

0 — No pain
10 — Worst pain