Adult Intake Form

WEST VALLEY CHIROPRACTIC

Name: _____ Occupation:_____
Address:_____ Marital Status: S M D W Spouse's Name: _____
City: _____ Prov: ___ Postal Code: _____ No. of Children: _____
Phone (H)_____ Other_____ Name of Family Doctor: _____
Email: _____ Alberta Health Care # _____
Date of Birth _____ Age _____ Referred By: _____

Chiropractic History

Have you previously seen a chiropractor? o Yes o No Reason _____ Did they take x-rays? o Yes o No
If yes, when was your last visit and how long did you receive care? _____

Current Health Condition o I'm here for wellness and have no complaints (Please skip to the next section)

Reason for today's visit _____
Pain or problem started on _____ Why do you think the problem/pain started? _____

Pain is: o Sharp o Dull o Constant o Intermittent Pain is interfering with: o Work o Sleep o Routine o Other _____

What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is it worse during certain times of the day? _____ Is the condition getting progressively worse? o Yes o No
Other Doctors seen: _____ Any home remedies? _____

Other Symptoms:				
o Headaches	o Pins & Needles in Legs	o Fever	o Constipation	Other conditions, diseases, or
o Neck Pain / Stiff	o Pins & Needles in Arms	o Fainting	o Loss of Balance	concerns: _____
o Sleeping Problems	o Numbness in Fingers	o Cold Sweats	o Ear Infections	_____
o Back Pain	o Numbness in Toes	o Loss of Smell	o Asthma	_____
o Difficulty Swallowing	o Shortness of Breath	o Loss of Taste	o Allergies	_____
o Tension	o Fatigue	o Nausea	o Frequent colds/flu	_____
o Irritability	o Depression	o Diarrhea	o Menstrual Problems	_____
o Chest Pains	o Light Bothers Eyes	o Feet Cold	o IBS / Crohn's Disease	_____
o Stomach Upset	o Hands Cold	o Anxiety	o Ears Ring / Buzzing	_____
	o Loss of Memory	o Dizziness	o Multiple Sclerosis	_____

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____
Any work, sports, or other injuries? _____
Any medication you are currently taking? _____
Have you had surgery? o Yes o No What type? _____
Any significant family medical conditions/history? _____
Give a brief description of the physical nature of your work: _____
Rate you occupation stress (1-10, 10 being the most stressful): _____
What types of physical, emotional, and chemical stressors have you experienced? _____
_____

As a result of my chiropractic care, I would like to: (please check all that apply)

o Feel better quickly
o Improved function and performance
o Have a healthier spine and better postural alignment
o Have a better quality of life

Signature: _____ Date: _____