February 2023 **CHIROPRACTIC NEW PATIENT - INTAKE FORM**

BEACON HILL
CHIROPRACTIC AND MASSAGE

PATIENT HEALTH RECORD

As a full spectrum chiropractic clinic; we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Please complete this document so we are better able to address your specific health concerns and challenges. Chiropractic is great for a variety of reasons. Pain relief, injury recovery, mobility improvement, and correction of whatever is malfunctioning in the body, are all areas of healthcare our doctors are capable of treating.

Were you aware that:
◯ Y ◯ N - Doctors of Chiropractic work with the nervous system?
◯ Y ◯ N - The nervous system controls all bodily functions and system?

Full Name: _____ ***M / F / Other*** **AHC:** _____

Date of Birth (M/D/Y): _____ **Age:** _____ **Occupation:** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Home phone: _____ **Cell phone:** _____ **Work Phone:** _____

◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed** **Children? Y / N** **How Many?:** _____

Name of Spouse: _____ **Phone Number:** _____

Alternate Emergency Contact: _____ **Phone Number:** _____

If under 18, Name of Parents: _____

Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: _____ **Initials:** _____

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _____ ◯ Person: _____

◯ Current patient: _____

Experience with Chiropractic

Have you ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? _____

Doctor's name? _____ Reason for visit? _____

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ Job ◯ Sport ◯ Car accident ◯ Fall ◯ Chronic discomfort ◯ Injury ◯ Other

If job related, have you reported your accident to your employer? Y / N **Will this visit be part of a WCB claim**? Y / N

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: _____

When did this condition begin? _____ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Work/School ◯ Sleep ◯ Daily routine ◯ Exercise/Athletics

Please explain: _____

Have you seen anyone else for this condition? Doctor/clinician's name: _____

Type of treatment: _____ Result: _____

FULL NAME: _____

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Angina
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Hardening of arteries
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Pace maker
- ◯ Poor circulation
- ◯ Stroke
- ◯ Thrombosis
- ◯ Varicose veins

RESPIRATORY
- ◯ Asthma
- ◯ Chest pain
- ◯ Difficulty breathing
- ◯ Emphysema (short of breath)
- ◯ Pneumonia
- ◯ Pulmonary hypertension
- ◯ Tuberculosis

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea/Vomiting
- ◯ Ulcers

MUSCLE/BONE/JOINT/DISC
- ◯ Ankle swelling
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Cortisone injections
- ◯ Degenerative disease
- ◯ Fractures/Breaks: _____
- ◯ Inflammation
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Plates/Pins
- ◯ Rheumatoid arthritis
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Pain b/w shoulder blades
- ◯ Spinal disc problems
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Headache
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Difficulty with swallowing
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ Sleep loss
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Vision problems
- ◯ Whiplash

NEUROLOGICAL
- ◯ Alzheimer's/dimentia
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Multiple Sclerosis (MS)
- ◯ Narcolepsy/Insomnia
- ◯ Nerve damage: _____
- ◯ Numbness in arms/legs/ hands/feet/_____
- ◯ Parkinson's/ Seizures

SKIN CONDITIONS
- ◯ Keloid/Scarring
- ◯ Psoriasis
- ◯ Shingles
- ◯ Warts

WOMEN ONLY
- ◯ Cramps/back pain
- ◯ Infertility issues
- ◯ Irregular cycles
- ◯ Menopause
- ◯ Miscarriage
- ◯ New mother
- ◯ Nursing
- ◯ Painful menstruation
- ◯ Pregnant

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
- ◯ Cancer: _____ _____ (radiation/chemotherapy)
- ◯ Diabetes (I / II)
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ Infectious disease: _____
- ◯ Kidney disease
- ◯ Raynaud's
- ◯ Thyroid problems
- ◯ Tuberculosis
- ◯ Urinary system issues
- ◯ Other:_____

MENTAL HEALTH
- ◯ Alcohol/drug abuse
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Eating disorder
- ◯ Panic attacks
- ◯ Postpartum depression
- ◯ Psychiatric issues
- ◯ PTSD
- ◯ Stress

ALLERGIES

Allergic to: _____ _____

Reaction: _____ _____

◯ EpiPen? YES / NO

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications you are currently taking. Symptoms you present in clinic may be related to these medications. If you are unsure of your medications it is <u>imperative</u> that you let us know at your next visit.

◯ Acid reducers ◯ Birth control ◯ Blood thinners ◯ Muscle relaxers ◯ Stimulants
◯ Antidepressants ◯ Blood pressure meds ◯ Insulin ◯ Pain killers (NSAIDS/Ibuprofen)

Medications	Dosage	Duration	Reason
Nutritional supplements	Dosage	Duration	Reason

FULL NAME: _____

FAMILY HEALTH HISTORY

◯ Arthritis ◯ Depression ◯ Digestive issues/IBS ◯ High blood pressure ◯ Osteoporosis
◯ Cancer ◯ Diabetes ◯ Heart disease ◯ Multiple sclerosis ◯ Stroke

HEALTH & LIFESTYLE

	YES	NO	Frequency
Smoking			/day
Alcohol			/day
Coffee			/day
Cannabis			/day
CBD Oil			/day

Please note that treatment will be withheld for any patient under the influence of alcohol or non-prescription drugs

*How frequently do you consume/participate in the following **per day**?*						
	0	1-2	3-4	5-6	7-9	10+
Glasses of water						
Fruits/vegetables						
Sugary treats						
Salty treats						

*How frequently do you participate in the following **per week**?*					
	0x	1x	2-3x	4-5x	6+
Cardio exercise					
Strength training					

Describe your sleep habits: _____

How would you describe your energy? _____

Do you wear foot support/orthotics? ◯ Yes ◯ No Current height: _____ Current weight: _____

STRESS HISTORY – please list your current/past stressors

Biggest PHYSICAL stressors: _____

Most significant CHEMICAL/NUTRITIONAL stressors: _____

Source of MENTAL/EMOTIONAL stress: _____

Past motor vehicle accident? ◯ Yes ◯ No Date of accident: _____

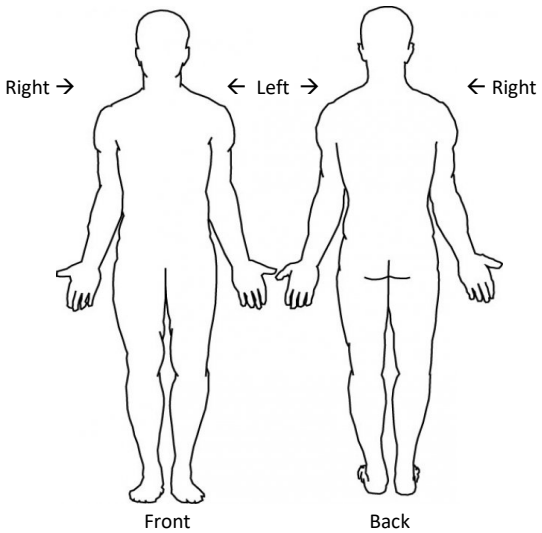
Past surgeries? ◯ Yes ◯ No Please list:_____

_____

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// Stabbing
XXXX Aching
Burning
>>>> Pins/Needles
0000 Numbness



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted