July 2019

CHIROPRACTIC REACTIVATION FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

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

REASON FOR THIS VISIT

Why are you back for care? ◯ Return visit based on original complaint ◯ To discuss treatment options for a new complaint

Please describe the reason for your visit: _____

_____

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

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

Are you currently suffering from any illness or being treated for any other condition by any type of health care provider? ◯ Yes ◯ No

Please explain: _____

Have you suffered any injuries or had any surgeries since you were last treated at our office?

Please explain: _____

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 imperative that you let us know at your next visit.

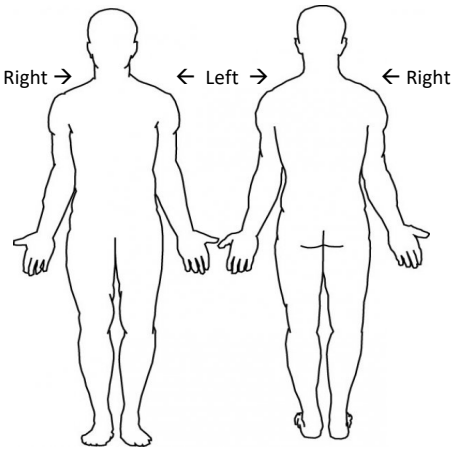
Please list any new or relevant medications or supplements you have taken since your last visit with us: _____

_____

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