March 2024

CHIROPRACTIC NEW PATIENT - INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

PATIENT HEALTH RECORD

As a full spectrum chiropractic clinic, our focus is on improving your health potential and wellness by addressing current issues and offering the most up to date services we can. Daily stress can impact health gradually, leading to serious issues. Chiropractic care helps with pain relief, injury recovery, and mobility, by correcting body dysfunctions and misalignments. Completing this document will help us address your specific health concerns so we can get you feeling your best.

Were you aware that:

- Doctors of Chiropractic work with the nervous system? ◯ Y ◯ N
- The nervous system controls all bodily functions and system? ◯ Y ◯ N **Date:** _____

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

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

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

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

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

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

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

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: _____ ◯ 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: _____

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

GOALS FOR CARE

◯ Relief of symptoms
◯ Correction of underlying problem
◯ Better perform work or recreational activities
◯ Improve my health and enhance my quality of life
◯ Maximize my own and my family's health
◯ Other: _____

FULL NAME: _____

Please **CHECK** any current/past conditions

1.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

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

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

4.GENERAL
- ◯ Night sweats
- ◯ Unexplained weight loss

5.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

6.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

7.NEUROLOGICAL
- ◯ Alzheimer's/Dementia
- ◯ 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

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

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

10.ALLERGIES

Allergy: _____

Reaction:_____

◯ EpiPen? YES / NO

11.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:_____

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

13.URINARY
- ◯ Frequent urination
- ◯ Hesitancy or dribbling
- ◯ Increased thirst
- ◯ Lack of urination
- ◯ Pain with urination
- ◯ UTI's

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/week
Alcohol			/day/week
Coffee			/day/week
Cannabis			/day/week
CBD Oil			/day/week

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

Current height: _____
Current weight: _____

*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					

HABITS

How is your sleep? _____ How many hours a night do you sleep? _____
Describe your energy: _____
What are your hobbies? _____
Do you wear foot support/orthotics? ◯ Yes ◯ No

STRESS HISTORY – list current/past stressors

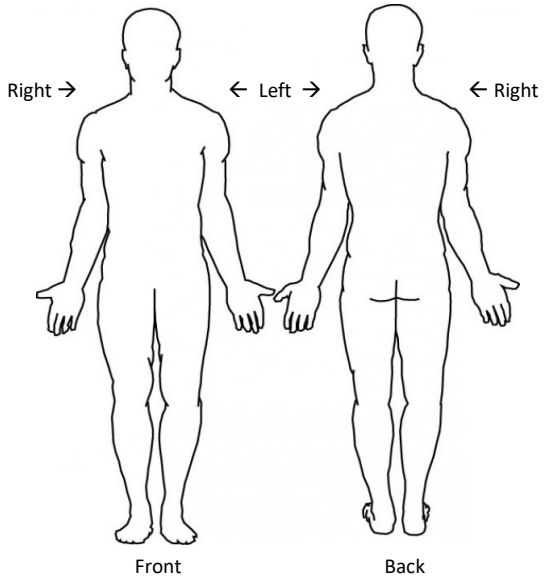
Past Motor Vehicle Accident? ◯ Yes ◯ No Date: _____ Describe: _____
Past surgeries? ◯ Yes ◯ No Please list:_____

PHYSICAL stress: _____ MENTAL stress: _____
NUTRITIONAL stress: _____ CHEMICAL stress: _____

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain or any sensations listed in 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