CHIROPRACTIC CENTRAL

PATIENT INTAKE FORM

PERSONAL INFORMATION		
First Name:		Last Name:
Date of Birth: Day / Month / Year Age:		Alberta Health Care #:
Address:		
City:	Province:	Postal Code:
Home Phone: ( )		Gender:
Cell Phone:( )		I would like to receive appointment reminders via text: YES NO
Email:		I would like to receive appointment reminders via email: YES NO
Emergency Contact Name:		Emergency Contact Phone:( )
Who referred you to our office?		Are you a student? YES NO

EXTENDED HEALTH CARE	
Primary Company Name:	Secondary Company Name:
Policy/Plan #:	Policy/Plan #:
Cert./ID #:	Cert./ID #:
Policy Holder Name/ Relationship:	Policy Holder Name/ Relationship:
Policy Holder DOB Day / Month / Year	Policy Holder DOB (D/M/Y): Day / Month / Year

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE			
Reason(s) for appointment?			
When did your condition begin?		Have you ever had similar problems? YES NO	
Have you had X-rays, MRI or other tests for this condition? YES NO		Which tests, when?	
Are you here as a result of a work-related injury? YES NO		Has your employer been notified? YES NO	
Are you here as a result of a Motor Vehicle Accident? YES NO		On what date did the accident occur? Day/ Month /Year	
Can you perform daily home activities (Please circle)	Yes	Yes, but only with help	Not at all
Can you perform your daily work activities? (Please circle)	All activities	Only some activities	Not at all
Describe your stress level: (Please circle)	None	Mild Moderate	High
Do you Exercise? (Please circle)	Daily	Occasionally	Not at all
What kind of exercises do you do?			
List all previous surgeries, illnesses, injuries (Including Motor vehicle accidents):			
Have you had previous chiropractic care? YES NO Dr.		Date:	
Name of family doctor:			
List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc:			

210 12C STREET NORTH
LETHBRIDGE, AB T1H 2M7
P: (403) 329-0922
WWW.LETHBRIDGECHIROPRACTOR.COM

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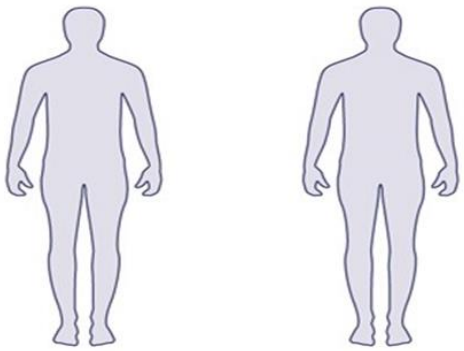
HEALTH HISTORY QUESTIONAIRE

Have you ever been diagnosed or told you have the following? *Please check yes or no*	**YES**	**NO**
High blood pressure		
Hardening of the arteries?		
Diabetes		
Tuberculosis		
Cancer If yes, where:		
Heart or blood disease		
Bone spurs on the neck bones (Cervical sprain)		
Whiplash injury (Flexion-extension injury, cervical sprain)		
Have you or any of your relatives ever suffered a stroke?		
Were you ever a smoker? From: To:		
Do you take medication on a regular basis?		
Visual disturbances (blurring, loss, double vision)		
Hearing disturbances (Loss, ringing, other noises)		
Slurred speech or other speech problems		
Difficulty swallowing		
Dizziness		
Loss of consciousness, even momentary blackouts		
Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms or any other parts of the body?		
Sudden collapse without loss of consciousness		

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No pain **Extreme pain**

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