Information reviewed with patient:

Dr. Initials_____

BRISBIN FAMILY CHIROPRACTIC

Today's Date_____

Adult intake form

The following information is collected in order to understand your full health picture and may be relevant to your present muscle, joint and/or nervous system symptom(s), diagnosis and/or prognosis.

The following information has been filled out to the best of my knowledge:

(Patient's signature) _____

PATIENT INFORMATION

Legal Name (First)_____(Last) _____

Preferred Name (if different from above) _____

Sex assigned at birth Male / Female Gender _____

Date of Birth _____ Age _____

Address _____ City _____

Postal Code _____ Cell # _____

Email _____ ☐ I do not want to be contacted through email

Employer/School _____ Occupation _____

Alberta Health Care # _____ Family Dr. _____

Spouse's Name _____

Name and Age(s) of Child(ren) _____

EMERGENCY CONTACT

Name _____ Relationship _____

Contact Number _____

Who may we thank for referring you? _____

Have you ever received chiropractic care? Yes / No

If yes, who and approximately when? _____

HOW CAN WE HELP YOU?

What brings you in today (please circle)? Specific concern Wellness Checkup

In your own words, describe the reason(s) for your visit _____

_____

When did the symptoms **begin**? _____

Have you had this or similar symptoms before? Yes / No

What **relieves** your symptoms? _____

What **aggravates** your symptoms? _____

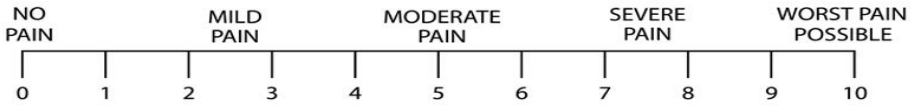
Does the pain **travel/radiate** anywhere? Yes / No _____

Is this due to a specific **injury**? Yes / No If yes, describe _____

Is this a work-related (**WCB**) injury? Yes / No Date of injury _____

Is this related to a **Motor Vehicle Accident**? Yes / No Date of accident _____

On the following scale, **how intense** are your symptoms at their worst? (circle)

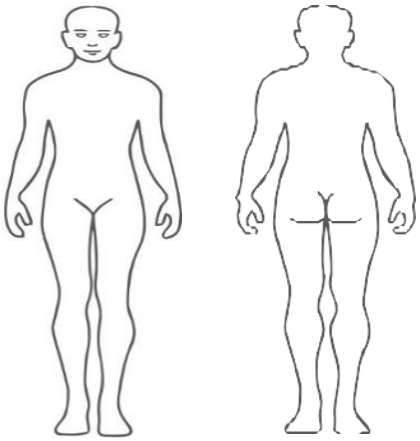


How does this problem affect your life? _____

Have you received any other treatments for this condition? _____

Using the diagram below, please **circle the areas** where you are experiencing symptoms and **place a descriptor** from abbreviations below, on how you would describe them.

Numbness (N)	Sharp pain (P)
Tingling (T)	Radiating pain (R)
Stiffness (S)	Burning (B)
Dull (D)	Throbbing (TH)
Aching (A)	Stabbing (ST)
Cramping (C)	Swelling (SW)



Is there a chance you are **pregnant**? Yes / No (**if pregnant, please fill out final section on page 3)

Have you received **spinal x-rays** in the last 2 years? Yes / No

Do you wear **orthotics** or special shoe inserts? Yes / No

Any significant **family health history** that may be important for the doctor to know? Yes / No

Please list: _____

Please list any current medications: _____

PAST HEALTH HISTORY (Please list any of the following **you have sustained,** along with **the year in which it occurred**

Surgeries _____

Head injuries/concussions _____

Broken bones _____

Motor vehicle accidents _____

Hospitalizations (including mental health crisis) _____

LIFESTYLE STRESSES (What we do on a daily basis affects how quickly our body can adapt and heal.)

What is your overall **stress level**? (0-10, 10 being most stressful) _____

How would you rate your **overall health?** (0-10, 10 being best health) _____

How many days a week do you **exercise** on average? _____

How would you rate your **quality of sleep**? Poor Average Great Avg # hours sleep _____

Where do you perceive your stress coming from (circle all that apply)

Family Work Finances Health Environment Lifestyle

Do you partake in any of the following chemical stressors (please circle)

Tobacco Alcohol Cannabis Caffeine Other: _____

REVIEW OF SYSTEMS

Please check off any conditions you **have, or have had** in the following list and mark if it's past (P) or current (C) beside the condition:

- ☐ Back pain
- ☐ Leg pain/ Sciatica
- ☐ Arm pain / Radiating pain
- ☐ Numbness / Tingling in Arms or Legs
- ☐ Neck pain
- ☐ Headaches / Migraines
- ☐ Ear or Sinus infections / Upper respiratory infections
- ☐ Vertigo / Dizziness / Balance concerns
- ☐ Tendonitis / Muscle tears
- ☐ Neurologic Disease / Seizures
- ☐ Diabetes
- ☐ Heart / Circulatory problems
- ☐ Stroke
- ☐ High or Low Blood Pressure
- ☐ Cancer
- ☐ Thyroid issues
- ☐ Stomach / Digestive problems / Heartburn
- ☐ Allergies
- ☐ Skin disorders
- ☐ Prostate Disease
- ☐ Painful/irregular menstrual cycles
- ☐ Hormone therapy
- ☐ Infertility/menstrual problems
- ☐ Impotency
- ☐ Mental health concerns (Depression, Anxiety, etc.)
- ☐ Insomnia / Sleep disturbances
- ☐ Low energy / Chronic Fatigue
- ☐ Osteoporosis
- ☐ Increased frequency with urination / Incontinence
- ☐ Constipation (recurring)
- ☐ Diarrhea (recurring)
- ☐ Hyperactivity / Behavior issues / ADHD
- ☐ Focus / memory issues / Brain Fog
- ☐ TMJ (jaw) pain
- ☐ Vision changes
- ☐ Unexplained weight loss / Weight gain
- ☐ Asthma
- ☐ Recent international travel

Please fill out the following section only if you are CURRENTLY PREGNANT*

When is your expected or calculated due date? _____

Approximately how many weeks pregnant are you? _____

Who is helping you with this pregnancy (circle all that apply)? Obstetrician Midwife Doula

Is this your first pregnancy? Yes / No If No, how many times have you been pregnant? _____

Have you had any complications in previous pregnancies? Yes / No

If yes, please explain _____

Do you wish to follow the same plan as your previous delivery? Yes / No

If No, explain _____

Please check any pregnancy-specific concerns you may have or have had:

- ☐ Breech presentation
- ☐ Transverse presentation
- ☐ Gestational Diabetes
- ☐ Pre-eclampsia
- ☐ Pelvic girdle pain
- ☐ Round ligament pain
- ☐ Unexpected spotting
- ☐ Diastasis Recti
- ☐ Previous Miscarriages
- ☐ Previous Stillbirth
- ☐ Acid reflux
- ☐ GI issues
- ☐ Vomiting
- ☐ Other: _____

Have you had any unexpected weight gain or weight loss during this pregnancy? Yes / No

Have you experienced any morning sickness? Yes / No

If yes, how would you rate your morning sickness? ☐ Typical for pregnancy ☐ Atypical for pregnancy

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CCPA

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____

Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature

Updated: September 2025