DALHOUSIE FAMILY CHIROPRACTIC

Patient Intake form

Complete this brief questionnaire and health history form to help us get to know you better. We will use this information to help formulate the recommendations for your care.

DATE: _____

PATIENT DEMOGRAPHICS

TITLE: *circle one: Mr. Mrs. Miss. Dr.* Name: _____ Male/ Female/ Other **AHC#** _____

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

Home Phone #: _____ **Cell Phone#:** _____ **Business #:** _____

Email: _____ *By providing your email address you consent to receive correspondence about appointment times and events at the clinic.*

Date of Birth: MM/DD/YY Age: _____ **Marital Status:** single ☐ Married ☐ Divorced ☐ Widowed ☐ Common-law ☐

Names and Ages of Children: _____

How did you first hear about us?: _____

Employer: _____ **Occupation:** _____

Name of Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

HISTORY OF COMPLAINTS

Please identify the complaints that have brought you into our office. Please rate the severity of your complaints

Primary: _____ 0 1 2 3 4 5 6 7 8 9 10

Secondary: _____ 0 1 2 3 4 5 6 7 8 9 10

Third: _____ 0 1 2 3 4 5 6 7 8 9 10

When did your primary problem begin? _____

How did the injury happen? _____

How often do you experience your primary complaint? Daily ☐ Weekly ☐ Monthly ☐

Does the pain radiate to any other body parts? Yes ☐ No ☐ If yes, where? _____

How long does the pain last? (ex. Constant, frequent, intermittent etc.) _____

What relieves your symptoms? _____ **What makes them feel worse?** _____

Can you perform daily home activities? Yes ☐ Yes with help ☐ Not at all ☐

Can you perform daily work activities? Yes ☐ Yes with help ☐ Not at all ☐ **Do the problem(s) effect your sleep?** Yes ☐ No ☐

Describe your stress: ***On the scales below please rate your stress on a scale of 0 to 10 (10 being the worst stress)***

Mental/Emotional 0 1 2 3 4 5 6 7 8 9 10 ***Physical*** 0 1 2 3 4 5 6 7 8 9 10

On the scale below, please rate your current nutrition (0 is poor nutrition and 10 is excellent nutrition)

Nutrition 0 1 2 3 4 5 6 7 8 9 10

Do you exercise? Not at all ☐ Daily ☐ Occassionally ☐ **What type of exercises do you do?** _____

Is this injury work related? Yes ☐ No ☐ **Is this injury a motor vehicle accident?** Yes ☐ No ☐

Have you had previous Chiropractic care? Yes ☐ No ☐

If yes, When? _____ **By Whom?** _____ **Frequency?** _____ **X-rays?** Yes ☐ No ☐

Have you been treated by other health care practitioners for your primary complaint?

Check all that apply **:** Massage ☐ MD ☐ Physiotherapist ☐ naturopath ☐ Acupuncturist ☐ Other ☐

What are your expectations with your visit today? Pain relief ☐ Find the cause of the complaint ☐ Maintenance ☐

Is there anything else you would like the doctor to know? _____

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PAST HEALTH

Have you ever suffered from any of the following conditions? Circle yes or no

Thyroid trouble	Y N	Tuberculosis	Y N	Emotional problems	Y N	Psoriasis	Y N
Diabetes	Y N	Pneumonia	Y N	Epilectic seizures	Y N	Alcoholism	Y N
High blood pressure	Y N	Back pain	Y N	Asthma	Y N	Polio	Y N
Heart disease	Y N	Headaches	Y N	Arthritis	Y N	HIV	Y N
Allergies	Y N	Stomach ulcers	Y N	Vanereal disease	Y N	Cancer	Y N

Please list any significant illness, operations, accidents, falls or traumas

DATE	Illness/ Operation/ Accident/ Falls
Vitamins	
Medications	

PRESENT HEALTH

Are you presently affected by any of the following? (past 12 months)

Please circle: **O** - Occassional **F** - Frequent **C**- Constant **Y** - Yes **N**- No

Stress Symptoms

headache/Migraine	O F C
Dizziness	O F C
Numbness	O F C
Ringing in ears	O F C
Blurring of vision	O F C
Loss of sleep	O F C
Loss of concentration	O F C
Irritable/nervousness	O F C
Depression	O F C
Decreased energy	O F C
Tension	O F C

Gastrointestinal

Difficult Digestion	O F C
Belching or Gas	O F C
Nausea/vomiting	O F C
Pain over stomach	O F C
Constipation	O F C
Colon Trouble	O F C
Liver Trouble	O F C
Gall bladder trouble	O F C
Heartburn	O F C
Diarrhea	O F C
Bloody stools	O F C

Reproductive Health

Painful menstruation	Y N
Irregular	Y N
Cramps or backache	Y N

General Symptoms

Fever/chills/sweat	O F C
Fainting	O F C
Convulsions	O F C
Allergies	O F C
Skin problems	O F C
Colds	O F C
Tremors	O F C
Loss of balance	O F C

Muscle and Joint

Back pain	O F C
Neck pain	O F C
Painful tailbone	O F C
Foot trouble	O F C
Shoulder pain	O F C
Hernia	O F C
Spinal curvature	O F C
Faulty posture	O F C
Arthritis	O F C

Respiratory

Chronic cough	O F C
Spitting up	O F C
Chest pain	O F C
Difficulty breathing	O F C
Abnormal discharge	Y N
Passed menopause	Y N
Birth control pill	Y N

Urinary

Painful urination	O F C
wake up at night to pee	O F C
Blood in urine	O F C
Increased urination	O F C

Eyes, Ears, Nose and Throat

Deafness	O F C
Earache	O F C
Sore throat	O F C
Tonsilitis	O F C
Sinus trouble	O F C

Cardivascular

Rapid heartbeat	O F C
Slow heartbeat	O F C
High blood pressure	O F C
Low blood pressure	O F C
Pain over heart	O F C
Swelling of ankles	O F C
Previous heart attack	Y N
Poor circulation	Y N
Previous Stroke	Y N

Are you pregnant? Y N

# of miscarriages _____

Date of last period _____