CHIROPRACTIC INTAKE & HISTORY

South Trail CHIROPRACTIC

PATIENT INFORMATION

Date: _____

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ Province _____ Postal _____

Primary Contact Phone # _____

Email _____

☐ Opt IN (this is for office communication Eg: Appointment reminders and Office Updates)
☐ Opt OUT

Sex: ☐ Male ☐ Female ☐ Other

Birthdate _____/_____/_____
MM DD YYYY

Who may we thank for referring you _____

Provincial Health Care Number _____

Health Care Benefits ☐ Yes ☐ No

Marital Status:
☐ Single ☐ Common Law ☐ Widowed ☐ Minor
☐ Married ☐ Separated ☐ Divorced

Occupation & Employer _____

Spouse's Name _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Contact Number _____

Relationship _____

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, emotional and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

HOW CAN WE HELP YOU?

I Wish to Have Chiropractic Wellness Services. If you have no symptoms or complaints, and are here for wellness services, please check **here** _____. Others please briefly describe the chief complaint, including the effect it has had on your life:

If you are already experiencing a symptom, what is it? _____

How long have you had this symptom? _____ **Is this condition work related?** ☐ Yes ☐ No (we are not a WCB provider)

Has this symptom happened before? ☐ Yes ☐ No

How intense are your symptoms (circle):

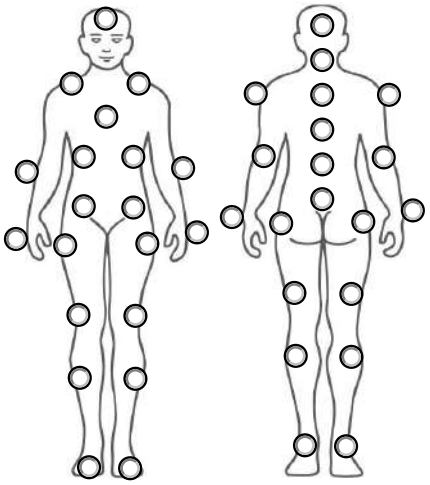
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1 NO SYMPTOMS — 10 INTENSE SYMPTOMS

What does it feel like? (check where appropriate)

☐ Stiffness ☐ Swelling
☐ Dull ☐ Numbness
☐ Cramping ☐ Tingling
☐ Sharp ☐ Aching
☐ Burning ☐ Stabbing
☐ Throbbing ☐ Nagging
☐ Other _____

Please circle areas to the right where you have pain or other symptoms:



Since the symptom started, is it getting …

☐ Worse ☐ Constant ☐ Better ☐ Intermittent (comes and goes)

What makes it better?

☐ Bed Rest ☐ Ice ☐ Heat ☐ Movement ☐ Chiropractic
☐ Medication ☐ Other _____

What makes it worse?

☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Other _____

Have you seen other doctors/therapists for this condition/symptom? ☐ Yes ☐ No

If yes, please list what type _____

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IMPACT OF YOUR SYMPTOMS

How is this symptom/ condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

NOT COMMITTED 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

Describe your lifestyle for each category using the scale:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Very Poor — Poor — Good — Excellent

	1	2	3	4	5	6	7	8	9	10
Diet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
General Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In what direction do you think your current lifestyle is currently heading?

☐ Getting Worse Quickly — ☐ Getting Worse — ☐ Getting Better — ☐ Getting Better Quickly

Do you currently play any sports or hobbies? _____

What are your health goals:

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have and their ages?

_____

Childrens' health concerns? _____

Have they had a spinal check-up? _____

If you are a woman, please answer the questions below:

Number of past pregnancies? _____

Are you currently pregnant? ☐ No ☐ Yes, due date: _____

Health concerns regarding this pregnancy? _____

YOUR HEALTH PROFILE

Have you ever received spinal adjustments by a Doctor of Chiropractic? ☐ Yes ☐ No

If yes, what was the doctor's name and when was your last visit? Doctor Name: _____ Last Adj. _____

How long were you receiving Chiropractic adjustments? _____ Why did you stop care? _____

FAMILY HEALTH HISTORY

Father's Side	☐ Heart Disease	☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Other _____
Mother's Side	☐ Heart Disease	☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Other _____

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YOUR HEALTH HISTORY CONTINUED …

Please check the box beside any condition that you have or have had:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Bladder/ Urinary Problems
- ☐ Back Pain
- ☐ Cancer
- ☐ Clicking Jaw/ TMJ
- ☐ Chest Pain
- ☐ Cold Sweats
- ☐ Cold / Tingling Circle (hands /arms/ legs/ feet)
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Constipation/ Diarrhea/ GERD/ IBS
- ☐ Stomach Upset/ Gas/ Bloating
- ☐ Dizziness
- ☐ Eczema
- ☐ Earaches
- ☐ Excessive Thirst
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue
- ☐ Gall bladder problems
- ☐ Hearing problems
- ☐ Headaches/ Migraines
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Joint Pain/stiffness
- ☐ Ringing in Ear/ Bussing in Ear
- ☐ Stroke
- ☐ Sleeping Problems
- ☐ Mental Disorder _____
- ☐ Menstrual Irregularities / Cramps
- ☐ Hot Flashes
- ☐ Balance Problems
- ☐ Nausea
- ☐ Neck Pain
- ☐ Walking Problems
- ☐ Osteoporosis
- ☐ Other _____

PHYSICAL STRESS

Other stressors throughout our life impact our body's ability to adapt and function. Please take a moment to consider the impact of past or current stresses. Have you experienced any of the following? (Please indicate if this happened in the past, or is a current or ongoing concern AND indicate the severity of the concern):

Falls ☐ Yes ☐ No / ☐ Mild ☐ Significant Explain: _____

Work Accidents ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Vehicle Accidents ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Sports Injuries ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Surgeries ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

CHEMICAL STRESS

Please check the box beside any condition that you have or have had:

Do you smoke? ☐ Yes ☐ No ☐ Past How many/day? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Past How many/week? _____

Do you drink coffee? ☐ Yes ☐ No ☐ Past How many/day? _____

Do you drink pop? ☐ Yes ☐ No ☐ Past How many/week? _____

Do you eat out frequently or eat junk food? ☐ Yes ☐ No ☐ Past How many/week? _____

List any Drugs you are presently taking (prescription/non-prescription, otherwise):

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____

EMOTIONAL STRESS

How would you describe your emotional health (circle): ☐ Excellent ☐ Good ☐ Fair ☐ Getting Better ☐ Getting Worse

Do you have any of the following stressors? (Please indicate if this was in the past or is current AND the severity)

School Stress ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Personal Relationships ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Stress from an Illness ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Work Related Stress ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Change in Lifestyle ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Abuse ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

Financial ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____

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PLEASE READ THE FOLLOWING CAREFULLY

I understand and agree that health and/or accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and/or receipts to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment each visit unless arrangements have been made with this center. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Name Print: _____ Signature: _____

Date: _____