CHIROPRACTIC INTAKE & HISTORY

loving life chiropractic

PATIENT INFORMATION

Date DD___MM___YY ___

Patient Name _____
FIRST NAME

_____
LAST NAME MIDDLE INITIAL

Address _____

City _____ Post Code _____ Prov____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday DD __MM___YY__

Who may we thank for referring you? _____

If not referral how did you hear about us? _____

Employer / School _____

Occupation _____

Marital Status: _____

Partner's Name _____

Partner's Occupation _____

YOUR HEALTHCARE PROVIDERS

GP _____ Last Seen _____ For _____

Chiro _____ Last Seen _____ For _____

Other _____ Last Seen _____ For _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

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

How bad is it? How intense are your symptoms? (circle)

☐ 0 NO SYMPTOMS ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 INTENSE SYMPTOMS

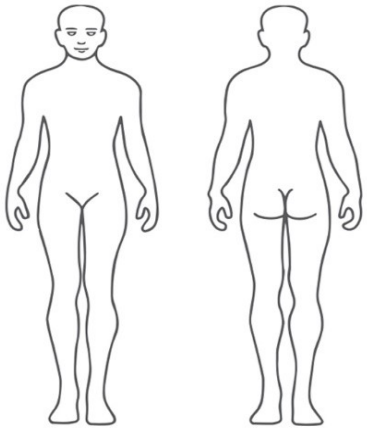
Please indicate main area of discomfort on diagram:

Sharp pain = #####

Dull ache = XXXX

Numbness/tingling = OOOO

Other = ++++ = (Please specify sensation) _____



IMPACT OF YOUR SYMPTOMS

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

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

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

Dr Craig Hindson & Dr Marie-Claude Lambert
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WHAT DO YOU LOVE DOING?

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram: a. which # do you think represents your health today ? Ans ____
b. where would you like to be (#) in 5 years time? Ans ____

With improved health what would the "Future You" like to achieve and for how long?

Things you love (circle/tick all that apply)	For the next: 0 - 6 mths	6m - 5yrs	5 - 20yrs	Other ____
☐ Play with kids ☐ grandkids ☐ great-grandkids	☐	☐	☐	☐
☐ Stay active in garden ☐ sports ☐ travel	☐	☐	☐	☐
☐ Improve your function ☐ stay strong and independent	☐	☐	☐	☐
Other _____	☐	☐	☐	☐
Other _____	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

CHILDREN & PREGNANCY

How many children do you have? _____

Children's ages? _____

Children's names? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Health concerns regarding this pregnancy? _____

_____

HEALTH & ILLNESS HISTORY

Tick ☑ for current AND past condition. FOR EACH TICK complete row below.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

HEALTH & ILLNESS HISTORY (continued)

For each **tick** ☑ above complete one row below.

Condition (If past write "PAST" before condition)	Date first noticed MM/YY	Cause?	Frequency per dy/wk/mth "c" = constant	If PAST condition write date ceased (MM/YY). If CURRENT write any other remarks

(If necessary continue on blank paper)

HEALTH TRAUMA HISTORY (include as much detail as possible e.g. MM/YY, what happened, hospitalised?)

Motor Vehicle Accidents:

Work & sports trauma:

Pregnancy Trauma:

Trauma as Child:

Surgeries:

Misc:

ALLERGIES, MEDICATIONS & SUPPLEMENTS

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

LIFESTYLE HABITS Indicate number in boxes below

On average approx how many...

a)...glasses wine, beer, alcohol/ week? ☐ glasses. b)...cigarettes / day? ☐ cigarettes. c)...medical pills / day? ☐ pills.

d)...supplement pills / day? ☐ pills. e)...hrs sleep / day? ☐ hours . f)...sessions of intense exercise / wk? ☐ sessions.

g)... meals/snacks with fresh vegetables/fruit per day? ☐ meals. h)...glasses water / day? ☐ glasses.

FAMILY HEALTH PROFILE Main Family Health Conditions

Children

Spouse

Mother Father

Brother Sister

Thank you for carefully completing ALL the sections of your intake form. This helps you better achieve your health goals and it helps us make the best descisions for your care. Please carefully read and sign the consent form over.

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Thank you for carefully completing ALL the sections of your official chiropractic intake & history form. Please carefully read and sign the consent form below.

CONSENT FOR A CHIROPRACTIC EXAMINATION & CARE

Extensive, prolonged, studies have show that qualified, well-trained chiropractors provide an extremely safe form of care.

Ethically, before starting your care, we need you to be informed of any risks so please read the following carefully.

Occasionally people under care experience mild healing effects and reactions such as muscle stiffness, local tenderness, tiredness, headaches, "flu-type" symptoms, release of emotions (such as crying) or dizziness. On very rare occasions 1 in 10,000 people report rib fracture. Whilst often reported anecdotally, serious injuries such as stroke are so extremely rare that they are reported as being less than 1 stroke per 2 million cervical adjustments. To put this into perspective, hospitalisations from the mildest of medical intervention such as a use of anti-inflammatory medications (e.g. Ibuprofen) are estimated at 40,000 per million (i.e. 80,000 times more likely) and deaths at 4000 per million (i.e. 8,000 times more likely), respectively.

In other words, receiving 80,000 adjustments has an equal risk to taking 1 ibuprofen pill.

I give consent to receive a chiropractic assessment which may include a non-intrusive thermal scan and a full hands-on examination at this practice.

If deemed appropriate by the Chiropractic Doctor I consent to receiving chiropractic adjustive care.

Signed by Patient or parent/guardian:_____

Date:DD _____ MM _____ YY 20____

Please only sign the next section after your second visit to the office

I have discussed with the chiropractic doctor the assessment of my condition and the care plan. I understand the nature of the care being provided to me. I have been informed of the benefits, risks and alternatives to chiropractic care. I hearby consent to receive chiropractic care as proposed to me.

Print Name: _____ Sign: _____

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