Welcome to Hands on Health Family Chiropractic!

Please fill out this form completely and accurately, to the best of your ability.
All the information requested below is necessary for us to serve you in the best way possible.

Today's Date: ____

ADULT INTAKE FORM

PERSONAL INFORMATION:

Name____
Age ______ Gender: Male __ Female __ Date of Birth (dd/mm/yyyy)_____________________________
Home Address____
City _____________________ Prov____ Postal Code _____________ Cell phone (____)
____
E-mail address ____
Preferred method of contact: ___ Text message ___ Email ___ Phone call
Occupation__________________________________Employer_______________________________________
Work Status Full Time Part Time Disability Student Retired Unemployed
Marital Status S M Partner D W Name of Spouse/Partner_______________________________
Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE:

Please describe why you have come to Hands on Health Family Chiropractic today.
____
____
____

What are your three main health goals/concerns (can include any goal from any category - nutrition, exercise, wellness, mental health, lifestyle, sleep, etc)?
____
____
____

HEALTH CARE PRACTITIONER HISTORY:

Previous Chiropractor? __Yes __No Name ____
What City/Town? ________________________________Date of last visit?(mm/yy) ____________________
Name of Medical Doctor ____
Phone ____________________________________Date of last visit? (mm/yy)_________________________

Other Health Care Professionals: ____

Dr. Stacey Farquhar, DC Dr. Matthew Garofolo, DC
4939 Dundas Street West, Toronto, ON M9A 1B6 Telephone 416 237 0069 Fax 416 237 9319 Email info@handsonhealthchiro.com Web www.handsonhealthchiro.com

HANDS ON HEALTH
FAMILY CHIROPRACTIC

TRAUMA HISTORY:

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips? ___Yes ___No
Please Explain:____

Have you ever broken any bones or sprained any part of your body? ___Yes ___No
Please Explain:____

Have you ever been hospitalized or had any previous surgeries? ___Yes ___No
Please Explain:____

Do you regularly suffer from or experience any of the following? (Yes=Checkmark No=Leave Blank)							
	Allergies		Gas/Bloating		Headache/Migraine		Thyroid Problems
	Skin Problems		Difficulty Digesting Food		Difficulty Concentrating		Getting up at night to Urinate
	Flu/Colds		Heartburn		Difficulty Remembering		Asthma
	High Blood Pressure		Constipation		Fatigue		Sinus Problems
	Low Blood Pressure		Increased Urination		Frequently Irritable or Angry		Previous Cancer
	Previous Heart Attack		Decreased Urination		Anxiety		Birth Control Pill/Shot
	Previous Stroke		Loss of Sleep		Depression		Painful or Irregular Menstruation

Please list all medications (prescribed or over the counter):
____
____

Please list all current Supplementation/Vitamins
____
____

Are you a Parent? If so, how old are your kids? ____

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HANDS ON HEALTH
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How stressed do you feel on a scale of 0-10

Professional/Job-related?

Stress Free					Moderate					Overwhelmed
0	1	2	3	4	5	6	7	8	9	10

Personal life?

Stress Free					Moderate					Overwhelmed
0	1	2	3	4	5	6	7	8	9	10

Do you drink coffee? How many cups per day, on average? ____
How much water do you drink per day, on average? ____

Do you smoke cigarettes on a daily basis? __Yes __No
How many per day, on average? __ For how long?_____

Do you drink alcohol regularly? __Yes __No
Type of alcohol consumed? _______________________ How many per week? ______________________

Other types of substance/drug use and frequency? ____

What type of exercise do you currently partake in?____
Days per week?__________________________ Time per workout?_________________________________

Sleep: Position?__________________________ Bedtime?____
Fall asleep easily?__Yes __No; Stay asleep?__Yes __No; Number of Times Awake at Night ___________

FINANCIAL INFORMATION

Payment in full is expected on all first visit services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing. We accept Visa, Mastercard, Interac, AMEX, Cash or Cheque.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. You are responsible for payment of all services at the time of service. We will gladly supply detailed receipts for you to submit to your insurance company for reimbursement.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctors at Hands on Health Family Chiropractic permission to render care to me today.

Name (Please Print) :____
Signature____ Today's Date___________________________

Thank you for choosing Hands on Health Family Chiropractic.
We look forward to helping you improve your health and well-being.

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