Dr. Darrin Thorvaldson
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CHIROPRACTIC

Intake Form

Background Information

Full Name:_____ Preferred name if different:_____

Date of Birth:_____ Age: _____ Sex: _____

Height (feet and inches): _____ Weight (pounds): _____

Manitoba Health Numbers: **MHSC (6 digits)**_____ **PHIN (9 digits)**_____

*** Manitoba residents: Manitoba Health pays a portion of your first 7 chiropractic adjustments in a calendar year**

Home Phone:_____ Cell Phone:_____

Email Address:_____ Occupation: _____

Street Address:_____

Married? ☐ Yes ☐ No Do You Have Children? ☐ Yes ☐ No Ages? _____

How Did You Hear About Our Office? _____

Emergency Contact: _____ Phone:_____

Why is this form so important? Because our office focuses on maximizing health. Our goals are to address the issue that brought you to this office and to offer the opportunity to learn and improve your health potential for the future.

Reason For Visit Today

Do You Have a Health Concern? ☐ Yes ☐ No **Are You Seeking Wellness Care?** ☐ Yes ☐ No

What is Your Health or Symptom Concern:_____

Symptoms Frequency?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (1-25%)

Rate Your Problem Between 0-10 _____ (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst Pain)

Do You Consider the Problem Severe? ☐ Yes ☐ No ☐ Sometimes

Your Problem Began How?_____

Have You Had a Previous or Similar Problem? ☐ Yes ☐ No

Problem Lasting How Long?_____

Symptoms Over Time? ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Anything Make It Worse?_____

Anything Make It Better?_____

Have You Had Previous Care?_____

Who Have You Seen For Your Problem?_____

Do you suffer with any other health condition other than why you are seeking care?

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care in our office.

Health History Section Check All That Apply

General:

- ☐ Fatigue
- ☐ Allergies
- ☐ Asthma
- ☐ Head Feels too Heavy
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Ringing in the Ears
- ☐ Poor Quality of Sleep
- ☐ Trouble Staying Asleep
- ☐ Weak Immune System
- ☐ Eczema/Psoriasis
- ☐ Headaches
- ☐ Migraines
- ☐ Cancer: _____

Nervous System:

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Twitching of the Face
- ☐ Stress
- ☐ Anxiety
- ☐ Often feel overwhelmed
- ☐ Trouble coping with daily living
- ☐ Brain Fog
- ☐ Confusion

Musculo-Skeletal:

- ☐ Low Back Pain
- ☐ Pain btw shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Clicking Jaw
- ☐ General Stiffness
- ☐ Inner Tension
- ☐ Arthritis
- ☐ Tendonitis/Bursitis
- ☐ Spinal Disc Problems
- ☐ Extremity Pain

Mental/Emotional:

- ☐ Addiction
- ☐ Compulsions
- ☐ ADHD
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Overeating
- ☐ Under eating
- ☐ Excessive exercise
- ☐ Panic attacks
- ☐ Use of alcohol: _____oz/per day
- ☐ Smoker: _____ /per day

Cardio-Vascular:

- ☐ Chest Pain
- ☐ Pins& Needles in Arms/Legs
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems ☐ High ☐ Low
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Angina

Male / Female:

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lump
- ☐ Infertility
- ☐ PMS
- ☐ Sexual Dysfunction
- ☐ Hormonal Imbalance
- ☐ Prostate Condition

Urinary:

- ☐ Bladder Troubles
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

Gastro-Intestinal:

- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Nervous Stomach
- ☐ Ulcers
- ☐ Gas/Bloating after meals
- ☐ Colitis/Crohn's
- ☐ Irritable Bowl Syndrome
- ☐ Indigestion

Eyes/Ears/Nose/Throat:

- ☐ Dental Problems
- ☐ Vision Problems
- ☐ Sore Throat
- ☐ Ear Aches/Infections
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Please State Any Family History Of Disease Or Illness: _____

Have You Been Hospitalized/Surgical Procedures? ☐ Yes ☐ No **Date(s):** _____

Have You Been In A Motor Vehicle Accident? ☐ Yes ☐ No **Date(s):** _____

Have You Had A Major Fall/Jolt/Impact? ☐ Yes ☐ No **Date(s):** _____

Additional Comments For 3 Previous Questions: _____

Do You Take Any Prescription/OTC Meds/Vitamins/Supplements? ☐ Yes ☐ No

List and Reason: _____

_____

How Would You Grade Your Diet?

☐ Great ☐ Good ☐ Average ☐ Poor

How Would You Grade The Level Of Stress In Your Life?

☐ None ☐ Mild ☐ Moderate ☐ Extreme

How Would You Grade The Level Of Stress In Your Past?

☐ None ☐ Mild ☐ Moderate ☐ Extreme