Campbell Chiropractic & Clinical Neuroscience-#102-21 Gladstone Ave. Oshawa, ON L1J 4E3

Chiropractic Intake Form by Dr. Cameron Campbell

Personal Information

Last Name:_____ First Name:_____

Email:_____ Date of Birth:_____ Age:____ Sex:____

Address:_____ City:_____

Province:_____ Postal Code:_____

Home#:_____Cell#_____

Occupation:_____ Employer:_____

Work #:_____

Medical Information

Name of Family Doctor:_____ Office #:_____

List of Surgeries in Past 5 years (Date and Type of Surgery)_____

_____

_____

# of Alcohol Drinks per week_____

# of Cigarettes per day_____

# of Caffeinated Drinks per day_____

# of cups of Water per day_____

# of hours of Exercise per week_____

Do you sleep on your back, side or stomach? _____

Do you wear Custom Foot Orthotics? _____. If Yes, how old is your current pair? _____

Who may we thank for referring you to our office? _____

Family History & ROS by Dr. Cameron Campbell NAME: _____DATE:_____

PLEASE TYPE "**YES**" FOR CONDITIONS OR SYMPTOMS YOU CURRENTLY HAVE

PLEASE TYPE "**FAMILY**" FOR CONDITIONS OR SYMPTOMS ANYONE IN YOUR IMMEDIATE FAMILY

PLEASE TYPE "**BOTH**" IF IT APPLIES TO BOTH YOU AND A FAMILY MEMBER

GENERAL SYMPTOMS: Blackouts _____Convulsions _____ Excess Sweating _____
Fever _____ Headache _____ Loss of sleep _____ Weight Loss _____
Nervousness _____ Night pain _____ Night Sweats _____

CARDIOVASCULAR: Angina _____ Chest pain _____ Atherosclerosis_____
Heart disease _____ Blood disease _____ High BP _____Low BP _____
Poor circulation _____ Stroke _____ Ankle Swelling _____ Varicose veins _____

SKIN: Shingles _____ Bruise easy _____ Dryness _____
Hives (allergies)_____ Rashes/itching _____

RESPIRATORY: Asthma _____ Chronic cough _____ Difficulty breathing _____

GASTROINTESTINAL: Belching/gas/indigestion _____ Constipation _____
Diabetes _____ Diarrhea _____Excess hunger _____Poor appetite _____
Gall bladder trouble _____ Hemorrhoids Jaundice _____ Ulcer _____
Vomiting _____

GENITOURINARY: Bedwetting _____ Blood in urine _____
Kidney infection _____ Prostate trouble _____ Trouble urinating _____

GU FOR WOMEN: Cramping _____Excessive flow _____ Hot flashes _____
Irregular Cycle _____Lump in breasts _____Painful menstruation _____
Vaginal discharge _____

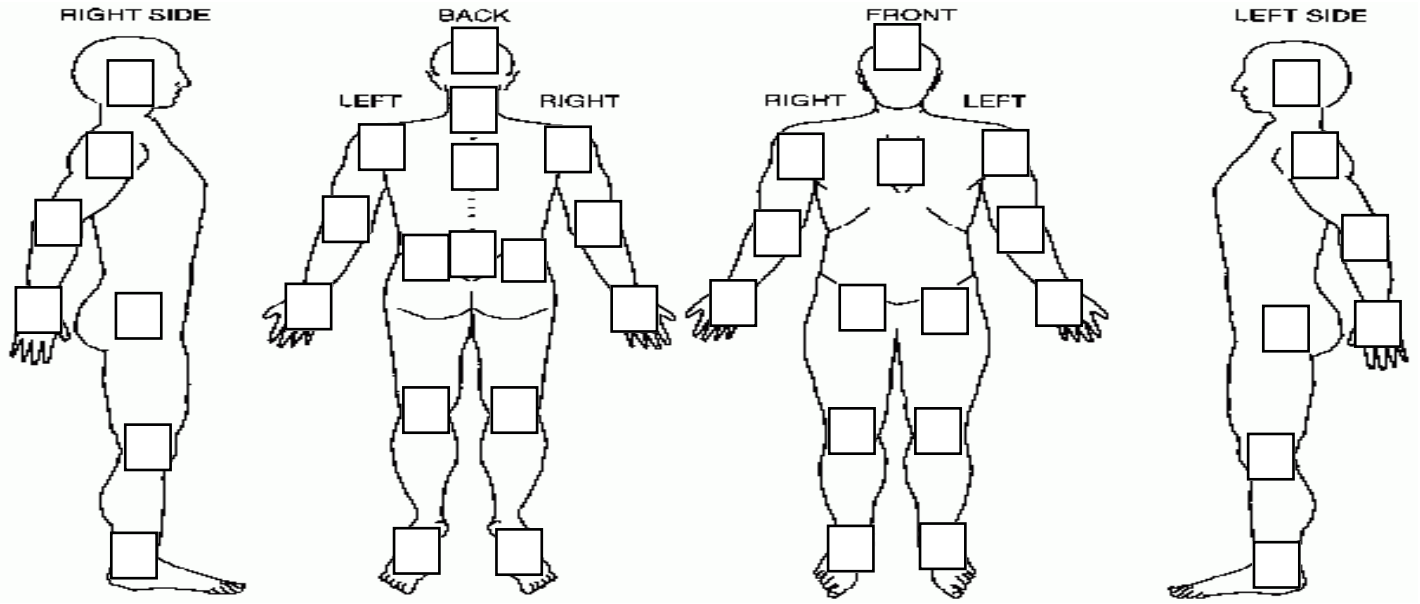
EYES/EARS/NOSE/THROAT: Earache _____ Enlarged glands _____
Enlarged thyroid _____Eye pain _____Failing hearing _____
Failing vision _____Frequent colds _____ Ring/buzz in ears _____
Sinus infections _____

NEUROLOGIC: Blurred vision _____Clumsiness _____ Dizziness _____
Double vision _____Fainting _____Nausea _____
Numbness or tingling _____ Problems speaking _____ Problems swallowing _____

Patient Signature: _____Date: _____

History by Dr. Cameron Campbell YOUR NAME: _____DATE:_____

Please check the area(s) where your you are having pain or problem(s). Please be as specific as possible.



COMPLAINT #1 Where is the problem area: _____

When did it start? _____

On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you can imagine what number would you give it today? ___ /10

What makes it worse? _____

What makes it better? _____

How would you describe the pain? _____

When is it at its worse? (morning, day, evening or night) _____

Pain radiates or refers to… _____

The pain is (better, worse, same) _____

The pain is (constant or comes and goes) _____

Is there any other information you feel we should know about this issue? _____

_____

_____

_____

History by Dr. Cameron Campbell YOUR NAME: _____DATE: _____

COMPLAINT #2 Where is the problem area: _____

When did it start? _____

On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you can imagine what number would you give it today? ___ /10

What makes it worse? _____

What makes it better? _____

How would you describe the pain? _____

When is it at its worse? (morning, day, evening or night) _____

Pain radiates or refers to… _____

The pain is (better, worse, same) _____

The pain is (constant or comes and goes) _____

Is there any other information you feel we should know about this issue? _____

_____

_____

_____

COMPLAINT #3 Where is the problem area: _____

When did it start? _____

On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you can imagine what number would you give it today? ___ /10

What makes it worse? _____

What makes it better? _____

How would you describe the pain? _____

When is it at its worse? (morning, day, evening or night) _____

Pain radiates or refers to… _____

The pain is (better, worse, same) _____

The pain is (constant or comes and goes) _____

Is there any other information you feel we should know about this issue? _____

_____