CALGARY
CENTRE FOR HEALTH™

NEW PATIENT INFORMATION

NAME:______________________________________DATE OF BIRTH :______________

HOME # (   ) ______________WORK # (   )______________CELL # (   )________

ADDRESS: ____
RESIDENCE AND MAILING   CITY   PROV   POSTAL CODE

EMPLOYER: ______________________OCCUPATION: ______________________

SINGLE___MARRIED___DIVORCED___WIDOWED___SPOUSE NAME__________NO. OF CHILDREN:___

EMAIL ADDRESS:____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

In our clinic, 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 and wellness in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS (TO AGE 17)

Question	YES	NO	UNSURE
Did you have any childhood illnesses?	❑	❑	❑
Did you have any serious falls as a child?	❑	❑	❑
Did you play youth sports?	❑	❑	❑
Did you take / uses any drugs	❑	❑	❑
Did you have any surgery?	❑	❑	❑
Have you fallen / jumped from a height over three feet? (i.e.crib, bunk bed, trees)	❑	❑	❑
Were you involved in any car accidents as a child?	❑	❑	❑
Were there any prolonged use of medicine such as antibiotics or an inhaler?	❑	❑	❑
Did you suffer any other traumas (physical or emotional)?	❑	❑	❑
Were you vaccinated?	❑	❑	❑
As a child, were you under regular Chiropractic care?	❑	❑	❑

ADULT – (18 TO PRESENT)

Question	YES	NO
Do / did you smoke?	❑	❑
Do / did you drink alcohol?	❑	❑
Have you been in any accidents? If yes,	❑	❑
Do / did you play any adult sports?	❑	❑
Do / did you participate in extreme sports?	❑	❑

1) How many?_______

2) Approximate dates?____________

On a scale of 1 – 10 describe your stress level:

Occupational Stress: _________

Personal Stress: ___________

Have you had any surgery? ☐ ☐

On a scale of Poor, Good, Excellent describe your:

DIET:______________EXERCISE:___________SLEEP:___________GENERAL HEALTH:______________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THIS OFFICE

1. Briefly describe the chief area(s) of complaint, including the effect it has had on your life?______
   ____
2. Pain is: Sharp_______Dull_________Comes and goes______Travels________Constant________
3. Since the problem started, is it… About the same___Getting better______Getting worse______
4. What makes it worse:____
5. It interferes with: Work: ____ Sleep:___Walking:_____ Sitting:____Hobbies:____Leisure:_____
6. Other Doctors seen for this problem (please list):
   Chiropractor:_________________Medical Doctor:________________Other:_____________
7. PREVIOUS X-RAYS ____
8. Have you ever had therapeutic massage before? Y / N

(Woman only) Are you pregnant? Yes/ No Date of onset of last menstrual cycle___________________

Please circle all symptoms you have experienced (circle **P** for past, **C** for current), even if they do not seem related to your current problem.

P	**C**	Headaches	**P**	**C**	Pins and needles in legs	**P**	**C**	Fainting
P	**C**	Dizziness	**P**	**C**	Pins and needles in arms	**P**	**C**	Ringing in ears
P	**C**	Numbness in fingers	**P**	**C**	Diarrhea	**P**	**C**	Irritability
P	**C**	Numbness in toes	**P**	**C**	Loss of Smell	**P**	**C**	Cold Hands
P	**C**	Fatigue	**P**	**C**	Buzzing in Ears	**P**	**C**	Cold Feet
P	**C**	Sleeping Problems	**P**	**C**	Neck Stiff	**P**	**C**	Fever
P	**C**	Depression	**P**	**C**	Constipation	**P**	**C**	Menstrual Irregularity
P	**C**	Neck Pain	**P**	**C**	Loss of Taste	**P**	**C**	Menstrual Pain
P	**C**	Tension	**P**	**C**	Light bothers eyes	**P**	**C**	Problem Urinating
P	**C**	Cold Sweats	**P**	**C**	Nervousness	**P**	**C**	Stomach Upset

List any medications you are taking now for any reason: ________________________________

Have you ever……….Bought Bottled Water: Y / N
Belonged to a health Club: Y / N
Consumed vitamins or supplements: Y / N

The Calgary Centre for Health

New Patient Intake Form

Family History: M=Mother F=Father S=Sister B=Brother GP=Grandparent

[Self][M][F][S][B][GP] High Blood Pressure
[Self][M][F][S][B][GP] Heart Disease
[Self][M][F][S][B][GP] Thyroid Disease
[Self][M][F][S][B][GP] Kidney Disease
[Self][M][F][S][B][GP] Diabetes
[Self][M][F][S][B][GP] Cancer
[Self][M][F][S][B][GP] Asthma
[Self][M][F][S][B][GP] Migraine
[Self][M][F][S][B][GP] Seizures
[Self][M][F][S][B][GP] Anemia
[Self][M][F][S][B][GP] Arthritis

Parent deceased [M][F] Age:________ Cause:______________________________

Remarks:____

____

1. If you are not feeling any symptoms and are seeking wellness care please check here: ☐

2. Please use the body diagram beside to describe your symptoms. Mark all affected areas using the symbols below on the person in the diagram.

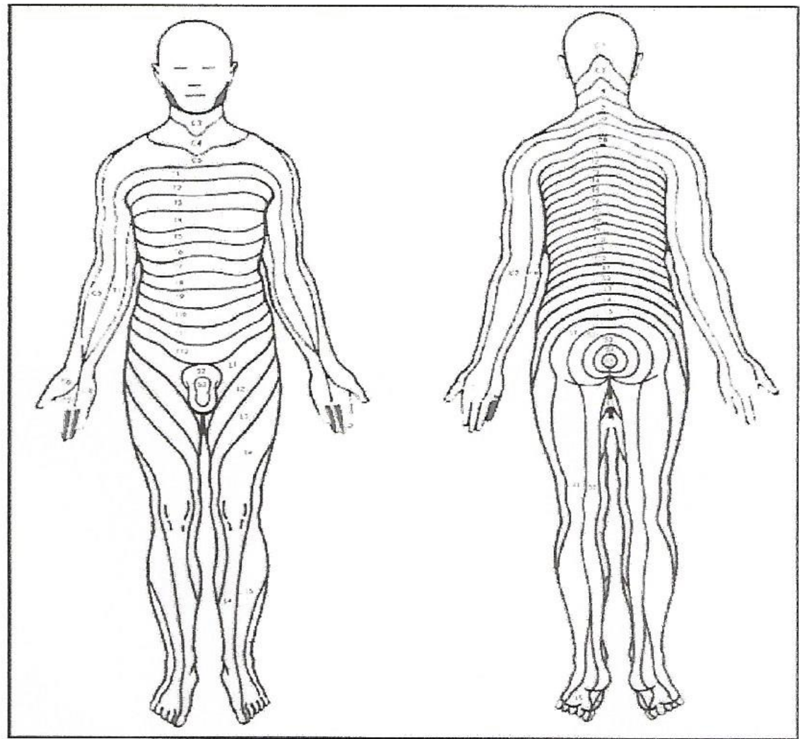
Numbness: ....
....

Pins & Needles: OOOOO
OOOOO

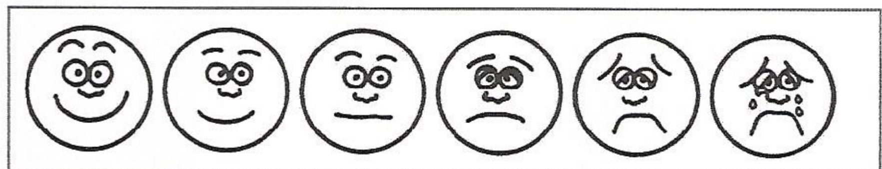
Burning: XXXXX
XXXXX

Aching: *******
****

Stabbing: ////////////
////////////



Please rate the pain you are feeling right now by circling the appropriate face.



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine

Patient Signature ______________________________ Date ____________