ASSINIBOINE CHIROPRACTIC INTAKE FORM

Patient's Legal Name:_____ Date of birth _____
First Middle Last Day Month Year

PHIN (9 digit):_____ MHSC (6 digit):_____ Marital Status: S M D W SEP

Address:_____
Street Address City Postal Code

Home Phone_____ Cell Phone_____ Email_____

EMAIL ADDRESSES ARE ONLY USED FOR OUR MONTHLY NEWSLETTER, CHANGE OF HOURS NOTICE AND BIRTHDAY GIFT OF A FREE VISIT.

Name of Parent/Guardian if patient is under 18 years old_____ _____ _

Occupation_____ Hours per week: _____ or ☐Student ☐Retired ☐Unemployed

How did you hear about our clinic? ☐Internet ☐Office sign ☐Phone book ☐Person_____

PATIENTS WHO REFER PEOPLE TO OUR OFFICE RECEIVE A FREE VISIT AS A TOKEN OF DR. LEADER'S APPRECIATION OF YOUR CONFIDENCE!!

INSURANCE

Insurance Co. _____ Group # _____ Contract # _____

Who is policy holder for this account? _____ Relationship to patient _____

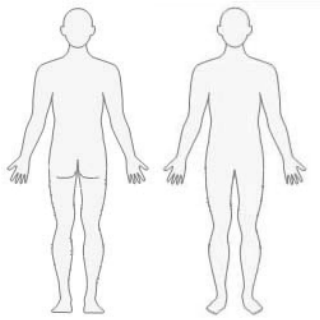
Is patient covered by additional insurance? ☐Yes ☐No If yes, explain _____

PATIENT CONDITION

Reason for Visit_____

When did symptoms begin?_____

Please mark an 'X' on the picture where you continue to have pain, numbness, or tingling



Have you ever had this discomfort before? _____

Is this problem… ☐Getting worse ☐Remaining the same ☐Getting better ☐Off & on

Is there anyone in your family with this type of problem? ☐Yes ☐No

Is condition due to an accident? ☐Yes ☐No When_____

Type of accident: ☐Vehicle ☐Work ☐Home ☐Other

HEALTH HISTORY

Have you seen a chiropractor before? ☐Yes ☐No If yes, who and how long ago? _____

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐None

☐Chiropractic Services ☐Other:_____ Date of last exam: _____

Medical doctor's: Name _____

Address_____

When approximately did you last have x-rays taken? _____ ☐Medical ☐Chiropractic ☐Dental

Height:_____ Weight:_____ Weight 1 year ago:_____ Are you taking any medication at all? ☐Yes ☐No

If yes, what kind and what for? _____

Have you ever: ☐Been hospitalized, had any serious illnesses, or operations?

☐Broken or dislocated any bones?

☐Been in a motor vehicle accident?

☐Had a serious fall or injury? (Childhood/adulthood)

If yes to any, please explain_____

_____

REVIEW OF SYSTEMS

Please check the appropriate answer:

✓Yes = A condition you're experiencing *now*
✓No = A condition you've *never* had
✓Past = A condition you've *had* in the past

AIDS / HIV?	☐Yes	☐No	☐Past	High Blood Pressure (Hypertension)	☐Yes	☐No	☐Past
Alcoholism	☐Yes	☐No	☐Past	High Cholesterol	☐Yes	☐No	☐Past
Allergy Shots	☐Yes	☐No	☐Past	Kidney Disease	☐Yes	☐No	☐Past
Anemia	☐Yes	☐No	☐Past	Liver Disease	☐Yes	☐No	☐Past
Anorexia	☐Yes	☐No	☐Past	Measles	☐Yes	☐No	☐Past
Appendicitis	☐Yes	☐No	☐Past	Migraine Headaches	☐Yes	☐No	☐Past
Arthritis	☐Yes	☐No	☐Past	Miscarriage	☐Yes	☐No	☐Past
Asthma	☐Yes	☐No	☐Past	Multiple Sclerosis	☐Yes	☐No	☐Past
Bleeding Disorders	☐Yes	☐No	☐Past	Mumps	☐Yes	☐No	☐Past
Bone Spurs on the Neck Bone	☐Yes	☐No	☐Past	Osteoporosis	☐Yes	☐No	☐Past
Breast Lump	☐Yes	☐No	☐Past	Pacemaker	☐Yes	☐No	☐Past
Bronchitis	☐Yes	☐No	☐Past	Parkinson's disease	☐Yes	☐No	☐Past
Bulimia	☐Yes	☐No	☐Past	Pinched Nerve	☐Yes	☐No	☐Past
Cancer	☐Yes	☐No	☐Past	Pneumonia	☐Yes	☐No	☐Past
Cataracts	☐Yes	☐No	☐Past	Polio	☐Yes	☐No	☐Past
Chemical Dependency	☐Yes	☐No	☐Past	Possibility You're pregnant	☐Yes	☐No	☐Past
Chicken Pox	☐Yes	☐No	☐Past	Prostate Problem	☐Yes	☐No	☐Past
Diabetes	☐Yes	☐No	☐Past	Psychiatric Care	☐Yes	☐No	☐Past
Emphysema	☐Yes	☐No	☐Past	Rheumatoid Arthritis	☐Yes	☐No	☐Past
Epilepsy	☐Yes	☐No	☐Past	Sexually Transmitted Disease	☐Yes	☐No	☐Past
Fractures	☐Yes	☐No	☐Past	Stroke	☐Yes	☐No	☐Past
Glaucoma	☐Yes	☐No	☐Past	Thyroid Problems	☐Yes	☐No	☐Past
Goiter	☐Yes	☐No	☐Past	Tonsillitis	☐Yes	☐No	☐Past
Gout	☐Yes	☐No	☐Past	Tuberculosis	☐Yes	☐No	☐Past
Hardening Of The Arteries (Arteriosclerosis)	☐Yes	☐No	☐Past	Tumors, Growths	☐Yes	☐No	☐Past
Heart Or Blood Vessel Diseases	☐Yes	☐No	☐Past	Ulcers	☐Yes	☐No	☐Past
Hepatitis	☐Yes	☐No	☐Past	Vaginal Infections	☐Yes	☐No	☐Past
Hernia	☐Yes	☐No	☐Past	Whiplash	☐Yes	☐No	☐Past
Herniated Disc	☐Yes	☐No	☐Past	Whooping Cough	☐Yes	☐No	☐Past

Manitoba Health partially covers the first twelve visits of each calendar year. I AGREE to pay the remaining amount at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of administrative fees, as well as other applicable fees. If necessary a receipt will be printed or emailed for your private insurance coverage and/or income tax purposes.

SIGNATURE OF PATIENT (OR PARENT OR LEGAL GUARDIAN) _____

DATE OF CONSENT: _____