Chiropractic Intake Form

Patient Information

Name: _____

Street Address: _____ APT# _____

City: _____ Prov. _____ Postal code _____

Home Phone: _____ Cell _____

Work Phone: _____ ext. _____ Fax _____

E-mail: _____

Birth Date (dd-mm-yy): _____ Shoe Size: _____

Height: _____ Weight: _____

Gender: ☐Male☐Female

Marital Status:
☐ Single☐ Married ☐ Separated ☐ Divorced ☐ Common law

Name of spouse/Significant Other:_____

Number of children: _____

Your occupation: _____ Employer: _____

Who recommended our services to you? _____

Have you received ***chiropractic***care previously? _____

If so, when? _____ Name of practitioner:_____

For what reason?_____

Primary Health Concern

What is your primary reason for seeking our care? Please explain below.

When and how did this condition begin?

Was there an injury, trauma or health significant event that may be a contributing factor?

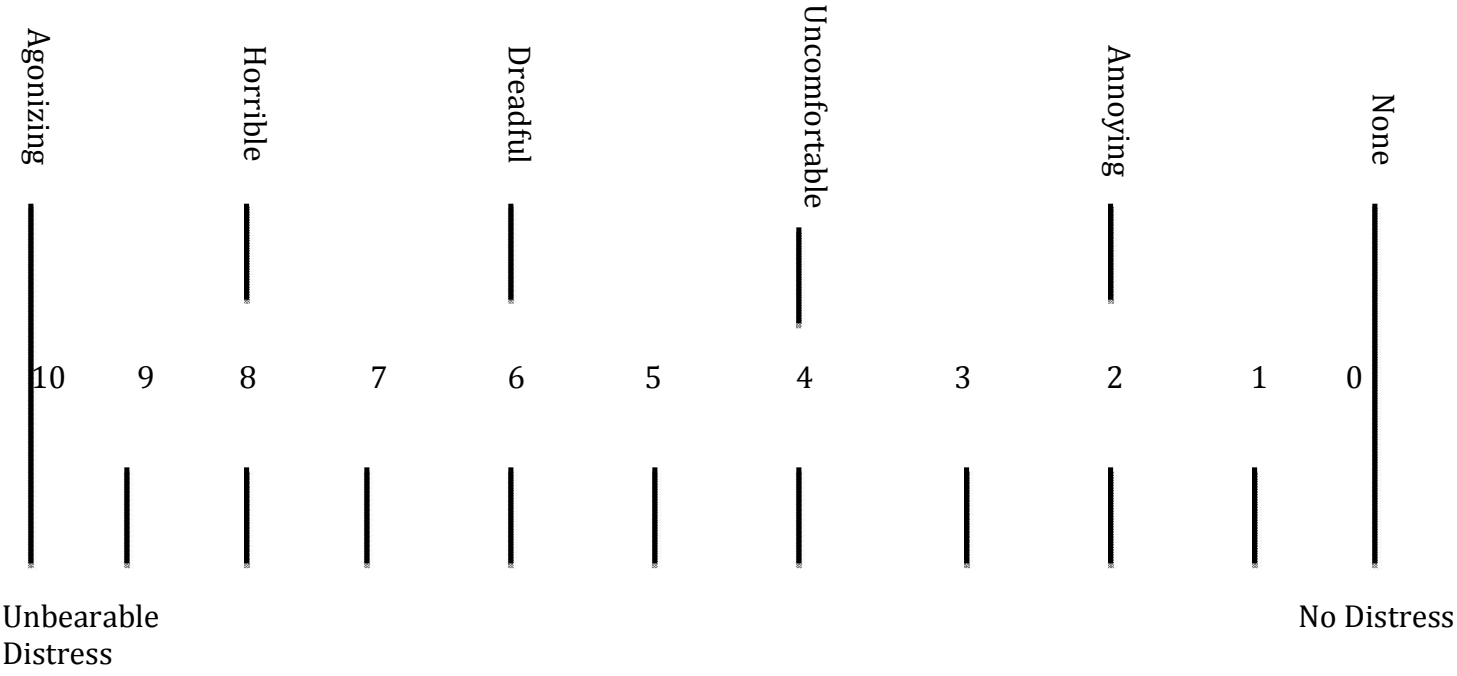
Did your condition happen: ☐ at work? ☐ in a motor vehicle accident? ☐ neither

Have you experienced a similar challenge in the past? If so, please explain below:

Have you been examined by another practitioner for this? ☐ Yes ☐ No

What was found and/or done?

Please indicate below the intensity of any discomfort youfeel now:



Affinity Health Clinic, 3 Waterloo Street, New Hamburg, ON N3A 1S3
Patient Name: _____
Healthcare provider_____

Is your area of concern: ☐ getting better ☐ staying the same ☐ getting worse

Why do you think so?

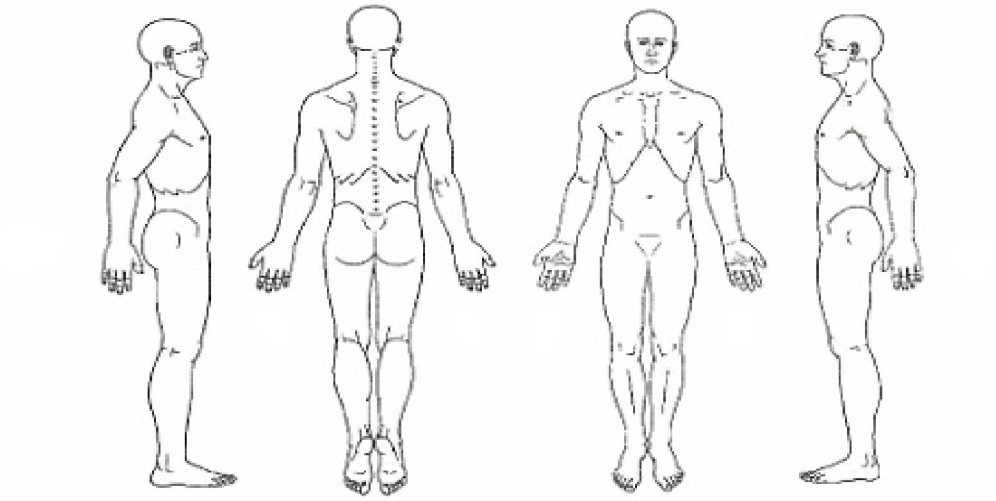
What activities, factors or positions aggravate your symptoms?

How often do you experience your symptoms?

What, if anything, have you found to relieve or improve your symptoms?

Indicate the areas of discomfort on the diagram by using the following symbols:

Sharp pain XXXXX **Dull ache OOOOO** **Numbness .....**
Tightness ///// **Tingling** +++++



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Describe how it feels when the symptoms are at their worst?

Do your symptoms radiate to areas other than the primary area? If yes, where?

From 1 to 10, 10 being highest, rate your commitment to correcting this problem: _____

Lifestyle

Stress Level: ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐Absent

Please circle the types of stress that are or have been challenging for you:

Physical: Falls Accidents Injuries Repetitive Strain
Poor Posture Birth trauma

Psychosocial: Loss of loved ones Move of home Work/School
Mental/emotional abuse Family Financial/Legal
Sexual abuse Change in relationship

Chemical: Tobacco Alcohol Coffee/Tea Recreational drugs
Environmental toxins

In what position do you most commonly sleep? On your: ☐Side ☐Back ☐Front

Rate your satisfaction with your sleep from 1 to 10 (10 being the best sleep): _____

List the forms of exercise and recreational activities in which you currently participate:

Rate your satisfaction with your diet from 1 to 10 (10 being very healthy): _____

Health Care History

Date of last: Spinal Examination: _____ Physical Examination_____

Spinal X-Ray: _____ Dental X-Ray: _____

Bone Mineral Density Test: _____

Please list all surgical operations you have had of any kind, why you had them, the net result and the approximate dates:

Please circle any of the following therapies that you have had done:

Acupuncture Chiropractic Counseling Dentistry Homeopathy Massage

Therapy Medicine Naturopathy Nutrition Podiatry Physiotherapy

Reflexology Reiki Shiatsu Traditional Chinese Medicine

If any of these therapies were of unique value or clearly detrimental, please give details:

Have you taken any steps personally, beyond the above, to improve your health?

For Women Only

Date of your last menstrual period: _____

Are you using any means of contraception_____

With Respect to the questions below, please provide details where applicable, including dates: (you may use the back of this sheet if necessary)

Have you ever been knocked unconscious? ☐ Yes ☐No _____

Have you ever used crutches, a walker or cane? ☐Yes ☐No _____

Please list your family members with diagnosed health conditions

Please list the medications, prescriptions and over-the-counter, you now use:

Please list the supplements (vitamins, minerals, homeopathic remedies, etc) you <u>now</u> use:

Health Conditions (Past and Present)

Please check each of the diseases or conditions that you have **now (N)** or have had in the **past (P).** While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to any practitioner, if necessary:

General:
___Allergy
___Convulsions
___Dizziness
___Fatigue
___Headache
___Loss of Sleep
___Loss of Weight
___Anxiety/Depression
___Numbness
___Cancer
___Diabetes
___Thyroid Problems
___Epilepsy
___Hyperactivity

Numbness or pain:
___Shoulders
___Upper arms
___Hands
___Legs
___Feet
___Poor Posture
___Swollen Joints
___Gout
___Polio

Eyes, Ears, Nose, Throat:
___Asthma
___Frequent Colds
___Crossed eyes
___Deafness
___Ear Infections
___Ringing in Ears
___Eye Pain
___Vision Problems
___Nasal Obstruction
___Sinus

Respiratory:
___Chest Pain
___Chronic Cough
___Irregular Breathing
___Wheezing
___Emphysema

Genito-Urinary:
___Bed-Wetting
___Painful Urination
___Prostate Trouble
___Blood in Urine
___Veneral Disease

Gastro-Intestinal:
___Constipation
___Diarrhea
___Digestive Dysfunction
___Gall Bladder Trouble
___Hemorrhoids
___Liver Trouble
___Ulcers

Cardio-Vascular:
___High Blood Pressure
___Low Blood Pressure
___Poor Circulation
___Irregular Heart Beat
___Ankle Swelling
___Anemia
___Arteriosclerosis
___Stroke

Women Only:
___Menstrual Cramps
___Irregular Cycle
___Hot Flashes
___Are you pregnant:
___Yes ___No

Muscle and Joint:
___Arthritis
___Hernia
___Low Back Pain
___Neck Pain
___Pain between shoulder blades

Other (not listed):