Chiropractic Intake Form

THE STUDY
Wellness Studio

Name: _____ Male ____ Female ____ Other _____

Address: _____ City: _____ Prov: _____

Postal Code: _____ Phone: (c) _____ (h) _____

D.O.B: _____ Occupation: _____

Family Doctor: _____ How did you hear about us? _____

Email Address: _____

Emergency Contact Name: _____

Relationship: _____ Emergency Contact Phone Number: _____

Please circle, check or fill in answers where appropriate.

Reason(s) for appointment: _____

When did your condition begin?_____

Have you ever had similar problems? Yes No

Have you had X-rays, MRI, or other tests for this condition? Yes No

Which tests, when? _____

Is this a work related injury? Yes No Has your employer been notified? Yes No

Is this a Motor Vehicle Accident (MVA)? Yes No If yes, when did the accident occur? _____

Can you perform daily home activities? Yes Yes, but only with help Not at all

Can you perform your daily work activities? All activities Only some activities Not at all

Describe your stress level: None Mild Moderate High

Do you exercise? Daily Occasionally Not at all

What kinds of exercise do you do? _____

Have you had previous chiropractic care? Yes No Dr. _____

Date: _____ Patient signature: _____

The Study Movement & Wellness 13 - 30 Griffin Industrial Point, Cochrane, Alberta T4C 0A2
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Please indicate conditions you are experiencing or have experienced:

Please check all that apply

o High Blood Pressure

o Low Blood Pressure

o Diabetes

o Tuberculosis

o Cancer Type/Location:

o Heart Disease

o Blood Disease

o Bone spurs on neck (cervical sprain)

o Osteoporosis

o Whiplash Injury

o Have you ever suffered a stroke?

o Were/are you a smoker?

o Do you take any medications on a regular basis?

    o Which ones?

o Visual disturbances (blurring, loss or double vision)

o Hearing disturbances (loss, ringing or other noises)

o Dizziness/Vertigo

o Loss of consciousness (even momentary blackouts)

o Numbness, loss of sensation, strength or weakness in extremities or any other part of the body

o Sudden collapse without loss of consciousness

o Any other conditions or health concerns I should be aware of?

    o Which ones?

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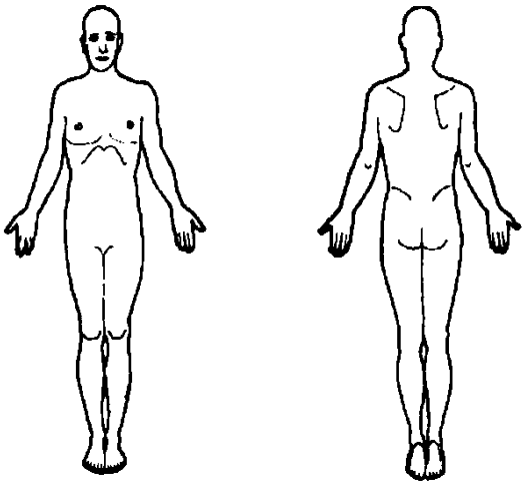
Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No pain — Extreme pain

Patient Name: _____ Date: _____

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Circle any conditions that are presently causing you a problem.
Underline those that have caused you problems in the past.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other:

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