Patient Intake

Date: DD/MM/YYYY

Name Last name , First Initials Goes By:

Address: Date of Birth DD/MM/YYYY

City: Prov: Postal Code: MHSC: 6 digit number

Parent/Guardian PHIN 9 digit number

Communication

Home Phone Cell Phone

Work Phone E-Mail

This information will only be used for emailing receipts and appointment reminders

Employment

Occupation Business Name :

Business Address: City Prov: Postal Code

General Questions

Have you been treated by a chiropractor before? ☐ Yes ☐ No When?

If yes, by whom?

Name of Medical Doctor: Address

Date of Last Medical Examination

Do you have reason to believe you may be pregnant? ☐ Yes ☐ No ☐ Possibly

Have you been x-rayed during the last 12 months? ☐ Yes ☐ No

List any surgeries or fractures

List any medications/vitamins that you are presently taking:

Have you had the following?

A history of cancer? ☐ Yes ☐ No

Unexplained weight loss? ☐ Yes ☐ No

Night pain, unrelated to movement? ☐ Yes ☐ No

Severe fever or chills? ☐ Yes ☐ No

A recent bacterial infection ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Pain in your arm/leg that is greater than your neck/back pain ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

If you have answered any of the above, please provide further information.

How did you hear about the office? ☐ Internet ☐ Website ☐ Google ☐ Yellow Pages ☐ Live in the area ☐ Doctor ☐ Family/Friend ☐ Mall Sign ☐ Facebook ☐ Instagram

What is their name?

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GENERAL HEALTH QUESTIONNAIRE

Please indicate which of the following may apply

MUSCULO-SKELETAL

- ☐ Lower back problems
- ☐ Neck problems
- ☐ Arm pain
- ☐ Swollen joints
- ☐ Leg pain
- ☐ Stiff joints
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Walking problems
- ☐ Ruptures (hernias)
- ☐ Broken/Fractured bones
- ☐ Dislocations
- ☐ Bone diseases
- ☐ Other

NERVOUS SYSTEM

- ☐ Clumsy hands or gait
- ☐ Tremors
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Frequent headaches
- ☐ Muscle twitching
- ☐ Convulsions/seizures
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Other

GASTRO-INTESTINAL

- ☐ Excessive appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Excessive gas
- ☐ Excessive bleeding
- ☐ Frequent nausea
- ☐ Vomiting blood
- ☐ Ulcers
- ☐ Frequent vomiting
- ☐ Intestinal infections
- ☐ Red or tar coloured stools
- ☐ Hemorrhoids
- ☐ Weight gain/loss
- ☐ Diabetes
- ☐ Irregular bowel moveme
- ☐ Indigestion

FEMALE ONLY

- ☐ Menopause
- ☐ Discharge from nipple
- ☐ Lumps in breasts
- ☐ Breast pain
- ☐ Vaginal discharge
- ☐ Abnormal mentruation
- ☐ Painful period
- ☐ Contraceptives
- ☐ Pregnancy Number
- ☐ Other

CARDIO-VASCULAR

- ☐ Racing heart beat
- ☐ Swelling of feet/ankles
- ☐ Varicose veins
- ☐ Fainting spells
- ☐ Blodd pressure problem
- ☐ Cramps in legs
- ☐ Poor circulation
- ☐ Jaundice
- ☐ Anemia
- ☐ Stroke
- ☐ Other

RESPIRATORY

- ☐ Constant cough
- ☐ Excessive phlegm
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Frequent bronchitis
- ☐ Wheezing
- ☐ Smoker

GENITO-URINARY

- ☐ Irregular urination
- ☐ Painful urination
- ☐ bladder infections
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Discoloured urine
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Can't empty bladder completely
- ☐ Change in stream

EYES

- ☐ Blurring
- ☐ Bothered by light
- ☐ Infection
- ☐ Loss of vision
- ☐ Cataracts
- ☐ Other

EARS

- ☐ Pain
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Discharge in ear
- ☐ Infections
- ☐ Other

NOSE

- ☐ Discharge
- ☐ Sinus problems
- ☐ Other

MOUTH

- ☐ Bite plate for jaw
- ☐ Gum disease
- ☐ Bleeding gums
- ☐ Swollen gums
- ☐ Painful gums
- ☐ Change in taste
- ☐ Other

THROAT

- ☐ Hoarseness
- ☐ Frequent sore throat
- ☐ Difficulty swallowing

SKIN

- ☐ Rashes
- ☐ Colouration changes
- ☐ Lumps
- ☐ Bruise easily
- ☐ Other