Beyond Chiropractic

INTAKE FORMS

Name: ____

Address: ____

City: ____

Postal Code: ____

Date of Birth: Day _____ Month _____ Year _____ Age: _____

Telephone: Home ( ) Work ( )

Email Address: ____

Marital Status : __________________________ Number of Children: __________________

Family Physician : _______________________ Date of last physical exam: _____________

Have you had X-rays/CT scans/MRI in the past 3 to 6 months? ___________________________

Do you smoke? ________________ If yes, how many per day? _____________________

Medical/Family History: ____

Have you had previous Chiropractic therapy, physiotherapy, naturopathy, other? _____________

If yes, by whom? ________________________ Last chiropractic visit? __________________

How did you hear about us? ____

If you have Extended Health Care Insurance, please check your plan

HEALTH HISTORY

Purpose of this appointment: ____

Have you been treated for this condition before? ______________________________________

How long have you had this condition? ____

This condition began: suddenly ____________ gradually _______________

What makes the condition feel better: ____

What makes the condition feel worse: ____

The condition is: getting better ____ worse _______staying same ______ infrequent _________

The condition interferes with: work _______ sleep ________ daily routines ______

Other complaints: ____

Sports/Exercise History: ____

____

Describe a typical day at work (time spent sitting/standing/lifting etc.): ____________________

____

Do you wear orthotics? ______________ If yes, how long have you had them? ___________

List of medications and supplements: ____

____

List of any motor vehicle accidents, falls, fractures: ____________________________________

____

Any allergies? ____

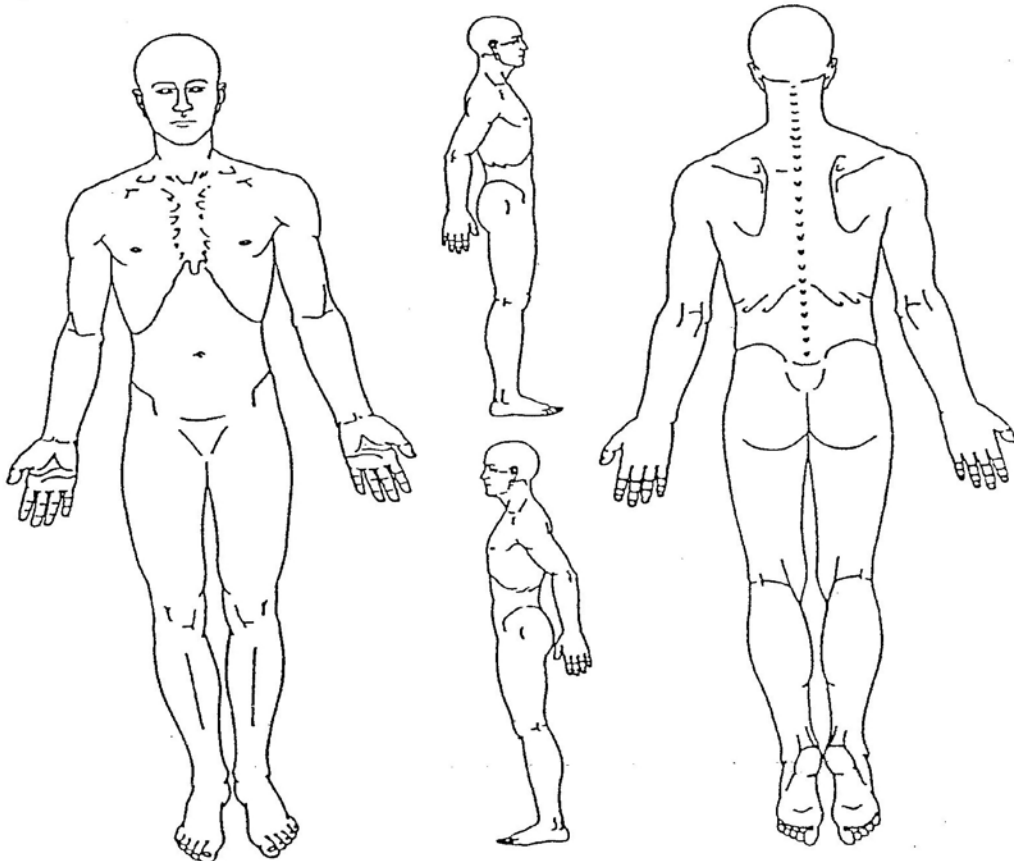
Bowel/bladder issues: ____

PAIN DRAWING

DATE: ____________________________ NAME: ______________________________

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) on the diagrams:

Numbness: N **Tingling: T** **Dull Pain: D**
Sharp Pain: P **Burning: B** **Stiffness: S**



Please indicate the severity of the pain by circling the number in the scale of zero to ten:

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

____
Patient Signature