māhāya
Health Services

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# CHIROPRACTIC PATIENT INTAKE FORM

Name:_________________________________ Birth Date:_______________ ☐Male ☐Female
Address: _____________________________ City:______________________ Prov:______ Postal: _________
E-Mail Address: ________________________ Home Phone: ______________ Mobile Phone: _______________
Marital Status: ☐ Single ☐ Married Do You Have Insurance? ☐ Yes ☐ No Work Phone: _______________
Employer:_______________________________ Occupation:_________________________________________
Name & Number of Emergency Contact ______________________ Relationship:__________________________
Name of Family Doctor: ___________________________________ Phone:______________________________
How did you hear about us? ___________________________________________________________________

**What is the reason for your visit?**

☐ **Pain Relief** ☐ **Stress Reduction** ☐ **Spinal/Posture Correction** ☐ **Health/Wellness/Vitality** ☐ **Improved Performance/Function**

**HISTORY OF COMPLAINT**

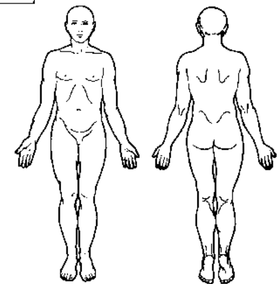
Please identify the condition(s) that brought you to this office: Primary: ______________________________
Secondary: ______________________ Third: _________________________ Fourth: ________________________

On a scale of **0** to **10** with **10** being the worst pain and **0** being no pain, rate your above complaints by circling the number:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Primary** or chief complaint is | : | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Second** complaint is | : | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Third** complaint is | : | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Fourth** Complaint is | : | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

When did the problem(s) begin? ___________________ When is the problem worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM
How long does it last? __________ **OR** ☐ It is Constant **OR** ☐ I experience it on and off through the day/week

How did the injury happen?_____________________________________________________________________
Has your condition ever been treated in the past? ☐ YES ☐ NO **IF YES,** When?____________ By Whom? __________
How long were you under their care:____________________ What were the results? _______________________
Name of Previous Chiropractor?______________________ ☐ N/A



***PLEASE MARK** the areas on the diagram with the following **letters** to describe your symptoms:
**R** = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harpness/**S**tabbing **T** = **T**ingling

What relieves your symptoms?______________________________
______________________________________________________
What makes them feel worse? ______________________________
______________________________________________________

**HOW IS THIS INTERFERING WITH:**
Work_____________________________________________________________________________________
Home:____________________________________________________________________________________
Leisure/Play:______________________________________________________________________________

Continued on other side…

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Is your problem the result of ANY type of accident? □ YES □ NO
Identify any other injury(s) to your spine or elsewhere, minor or major, that the doctor should know about:

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**PAST HISTORY**
Have you suffered with this or a similar problem in the past? □ YES □ NO **IF YES** how many times? ________________
When was the last episode?__________________________ How did the injury happen? ___________________________
Other forms of treatment tried: □ YES □ NO **IF YES**, please state what type of treatment: ______________________
Who provided the treatment?:______________________________ What were the results? □ Favourable □ Unfavourable

Please explain: ___________________________________________________________________________

Please identify any jobs you have had in the past that have had a physical impact on you or your body:

Please indicate if you have experience **ANY** of the following conditions, indicate **P = P**ast, **C = C**urrent:

__Broken Bone __Dislocations __Tumors __Rheumatoid Arthritis __Chronic Fatigue

__Heart Attack __Osteo Arthritis __Diabetes __Cerebral Vascular __Cancer
__Headache __Immune System Issue __Dizziness __Prostate Problems __Ulcers
__Neck Pain __Frequent Cold/Flu __Loss of Balance __Impotence/SexualDysfunction __Heartburn

__Jaw Pain, TMJ __Convulsions/Epilepsy __Fainting __Digestive Problems __Heart Problem
__Shoulder Pain __Tremors __Double Vision __Colon Trouble __High/Low BP
__Upper Back Pain __Chest Pain __Blurred Vision __Diarrhea/Constipation __High Cholesterol

__Mid Back Pain __Pain w/Cough/Sneeze __Ringing in Ears __Menopause Problems __Asthma

__Low Back Pain __Foot or Knee Problem __Hearing Loss __Menstrual Problems __Difficulty Breathing

__Hip Pain __Sinus/Drainage Prob __Depression __PMS __Lung Problems
__Poor Posture __Swollen/Painful Joints __Irritable __Bed Wetting/Bladder Issues __Kidney Trouble

__Scoliosis __Skin Problems __Mood Changes __Learning Disability __Gall Bladder

__Numb/Tingling Pain into arms, hands, fingers __ADD/ADHD __Eating Disorder __Liver Trouble

__Numb/Tingling/pain into legs, feet, toes __Allergies __Trouble Sleeping __Hepatitis (A,B,C)

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**PLEASE identify ALL PAST and ANY CURRENT conditions you feel may be contributing to your present problems:**

| | How Long Ago? | Type of Care Received | From Whom? |
|---|---|---|---|
| Injuries → | | | |
| Surgeries → | | | |
| Childhood Diseases→ | | | |
| Adult Diseases → | | | |

**FAMILY HISTORY**
Does anyone in your family suffer with the same condition(s) □ YES □ NO

If YES, who?: □ Grandmother □ Grandfather □ Mother □ Father □ Sister(s) □ Brother(s) □ Son(s) □ Daughter(s)
Have they ever been treated for their condition? □ Yes □ No □ Don't Know

**ARE THERE ANY OTHER CONDITIONS THAT THE DOCTOR SHOULD BE AWARE OF?** □ No □ Yes ( if yes please explain):

The Patient and/or Authorized Person agrees that they are responsible for the payment of all fees for services rendered. If the Patient has third party coverage (i.e. insurance coverage, health benefits, etc…) then, if for any reason, payment is not made for services rendered, the Patient and/or Authorized Person remain liable to pay any and all outstanding fees.

Signature: ________________________ Date: ____________________

(DD/MM/YYYY)

*Thank you for taking the time to fill out this questionnaire.*
*It will help greatly in my study of your present health concerns*
*and in my understanding of your health goals.*
*Your responses will assist me in choosing the appropriate treatment that will*
*bring about your return to optimal health.*