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## CHIROPRACTIC PATIENT INTAKE FORM

Address:	Name:					Birth	n Date:				□Male	□Fem	ale
E-Mail Address:   Home Phone:   Mobile Phone:   Marital Status:   Single   Married   Do You Have Insurance?   Yes   No   Work Phone:   Employer:   Occupation:   Relationship:   Name of Family Doctor:   Phone:	Address:				Cit	ty:				Prov:_		Postal:	
Marital Status:   Single   Married   Do You Have Insurance?   Yes   No   Work Phone:   Employer:   Occupation:   Relationship:   Name & Number of Emergency Contact   Relationship:   Phone:   P	E-Mail Address:				Но	ome Pho	ne:			Mobile	e Phone:	:	
Name & Number of Emergency Contact	Marital Status: □ Single □	Ma	rried	Do Yo	u Have I	Insuranc	e? □ Yes	□ No		Work	Phone: .		
Name of Family Doctor:													
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:   Fourth:   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  Third 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  How Ho do the problem(s) begin?   When is the problem worst?   AM   PM   M   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?   By Whom?    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 = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharpness/Stabbing T = Tingling    What makes them feel worse?   What makes them feel	Name & Number of Emerge	ency	/ Cont	act				Relat	tionship	o:			
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	Homou												



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

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:									
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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									
who provided the treatments:	DIC								
Please explain:									
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Discontinuation of the continuation of the continuation bearing the continuation of th									
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 <b>ANY</b> of the following conditions, indicate <b>P = P</b> ast, <b>C = C</b> urrent:									
Broken BoneDislocationsTumorsRheumatoid ArthritisChronic Fatigu	e								
Heart AttackOsteo ArthritisDiabetesCerebral VascularCancer									
HeadacheImmune System IssueDizzinessProstate ProblemsUlcers									
Neck PainFrequent Cold/FluLoss of BalanceImpotence/SexualDysfunctionHeartburn									
Jaw Pain, TMJConvulsions/EpilepsyFaintingDigestive ProblemsHeart Problem									
Shoulder PainTremorsDouble VisionColon TroubleHigh/Low BP									
Upper Back PainChest PainBlurred VisionDiarrhea/ConstipationHigh Cholester	ol								
Mid Back PainPain w/Cough/SneezeRinging in EarsMenopause ProblemsAsthma									
Low Back PainFoot or Knee ProblemHearing LossMenstrual ProblemsDifficulty Brea	thing								
	. 0								
Hip PainSinus/Drainage ProbDepressionPMSLung Problems	;								
Poor PostureSwollen/Painful JointsIrritableBed Wetting/Bladder IssuesKidney Trouble									
<u></u>									
ScoliosisSkin ProblemsMood ChangesLearning DisabilityGall Bladder									
Numb/Tingling Pain into arms, hands, fingersADD/ADHDEating DisorderLiver Trouble									
Numb/Tingling/pain into legs, feet, toesAllergiesTrouble SleepingHepatitis (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 Wnom?
	Injuries <del>&gt;</del>			
	Surgeries >			
	Childhood			
	Diseases →			
	Adult Diseases →			
	Y HISTORY nyone in your family	suffer with the same cond	ition(s) □ YES □ NO	
-		er □ Grandfather □ Mothe d for their condition? □ Ye	r 🗆 Father 🗆 Sister(s) 🗆 Brother(s) 🗆 s 🗆 No 🗆 Don't Know	Son(s) □ Daughter(s)
ARE TH	HERE ANY OTHER CO	NDITIONS THAT THE DOCT	OR SHOULD BE AWARE OF?   No	Yes ( if yes please explain):
If the F	Patient has third part	y coverage (i.e. insurance	y are responsible for the payment o coverage, health benefits, etc) the athorized Person remain liable to pay	n, if for any reason, payment is
Signatı	ıre:		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.