h e a l t h w o r k s
chiropractic & wellness centre
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Dr. Susan Lyons D.C., B.Sc., HBK

www.healthworkscentre.com

Date: _____

New Patient Intake Form

Name: _____ **Health Card #:**_____

Address: _____ City: _____ Province: _____ Postal Code: _____

Birth Date: __Day__/__Month__/___Year_____ Age: _____ **Gender**: ☐ Male ☐ Female

Please Circle One: Married Single Widowed Divorced Separated **Home Phone Number**: _____

Cell Phone Number: (_____) _____ Cell Phone Provider: Bell __ Rogers__ Telus__ Other_____

Email Address: _____ **How do you prefer reminders? ☐ Text ☐ Email**

Business/Employer Name: _____ Business Phone: _____ Occupation: _____

Spouse's Name: _____ Number of Children: _____ Ages: _____ Do you have insurance? ☐ Yes ☐ No

Who may we thank for referring you to this office? _____ ☐ Yellow Pages ☐ Advertisement ☐ Other_____

How will you be taking care of your account? ☐ Cash ☐ Cheque ☐ Visa ☐ MasterCard ☐ Interact

Emergency Contact Name: _____Relationship:_____ Contact Phone #: _____

Current Health Conditions

Current Complaints: _____

Family Doctor: _____ Does your MD know about this condition? ☐ Yes ☐ No

If yes, type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? _____

Is this condition: ☐ Job-Related (WSIB) ☐ Auto-Related ☐ Home Injury ☐ Fall ☐ Other _____

Date of Accident: _____ Time of Accident: _____

What aggravates your condition?

☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold ☐ Heat ☐ Dampness ☐Other _____

What relieves your condition?

☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Other _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes and Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Constant ☐ Inconsistent

Please describe how it feels when this problem is at its worse: _____

Please place an X on the grade indicating the severity of your pain. Least 1 2 3 4 5 6 7 8 9 10 Most

How does this problem at its worst interfere with:

Your ability to work: _____

Your ability to enjoy your family or social time: _____

Your ability to enjoy your hobbies or sports: _____

If you don't get this problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

Do you now take: ☐ Nerve Pills ☐ Insulin ☐ Painkillers / Muscle Relaxants ☐ Blood Pressure Medication ☐ Thyroid Medication

Please List all other **medications** you are currently taking: _____

P A G E 1 -> Turn over for Page 2

Do you suffer from any condition other than that for which you are now consulting us? _____

Past Health History

Have you had any previous imaging? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound

Please check or describe any major surgeries or operations:

☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Knocked Unconscious
☐ Broken Bones ☐ Surgical Implants / Devices _____
Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____
Hospitalization (other than the above): _____
Previous Chiropractic Care: ☐ None ☐ Doctor's name and date of last appointment _____
Were you satisfied with your chiropractic results? ☐ Yes ☐ No If no, why? _____

Family Health History

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____
Have your children ever had a spinal check-up? ☐ No ☐ Yes If yes, where and when? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Natural Health Care.

Check any of the following diseases you have had in the past or presently have:

☐ Cancer: (type: _____, date of diagnosis: _____)
☐ Thyroid: ☐ Hypo ☐ Hyper
☐ Eczema ☐ Psoriasis
☐ Diabetes: ☐ Type I ☐ Type II
☐ Depression
☐ Mental Disorder
☐ Pneumonia
☐ Whooping Cough
☐ Mumps ☐ Measles
☐ Influenza
☐ Rheumatic Fever
☐ Pleurisy
☐ Polio
☐ Chicken Pox
☐ Tuberculosis
☐ Epilepsy ☐ Seizures
☐ SARS
☐ HIV

Musculo-Skeletal System

☐ Arthritis
☐ Osteoporosis
☐ Neck Pain
☐ Shoulder Pain
☐ Upper Back
☐ Mid Back
☐ Low Back
☐ Arm Pain
☐ Legs
☐ Knees
☐ Feet
☐ Walking Problems
☐ Difficult Chewing / Clicking Jaws

Gastro-Intestinal System

☐ Bladder Trouble
☐ Painful / Excessive Urination
☐ Discoloured Urine
☐ Black / Bloody Stool
☐ Heartburn
☐ Gas / Bloating After Meals
☐ Colitis

Nervous System

☐ Stress ☐ Anxiety
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Convulsions
☐ Cold / Tingling Extremities
☐ Obsessive Defiance Disorder
☐ Obsessive Compulsive Disorder
☐ Attention Deficit Disorder
☐ Autism
☐ Down's Syndrome
☐ Developmental Disabilities
☐ Learning Disabilities
_____

Cardiovascular System

☐ Stroke ☐ Heart Attack
☐ Chest Pain ☐ Short Breath
☐ Blood Pressure ☐ High/☐ Low
☐ Pacemaker
☐ Irregular Heartbeat
☐ Ankle Swelling
☐ Fainting

Respiratory System

☐ Lung Problems
Cough/Congestion
☐ Varicose Veins
☐ Emphysema
☐ Bronchitis

General

☐ Fatigue
☐ Loss of Sleep
☐ Fever

Allergies

☐Environmental: _____
_____
☐Food: _____
_____
☐Medications: _____
_____

EENT

☐ Headaches ☐ Migraines
☐ Vision Problems
☐ Dental Problems
☐ Sore Throat ☐ Stuffed Nose
☐ Ear Aches ☐ Hearing Difficulty

Intake

☐ Coffee Daily _____ Wkly _____
☐ Tea Daily _____ Wkly _____
☐ Alcohol Daily _____ Wkly _____
☐ Cigarettes Daily _____ Wkly _____
☐ White Sugar

Do you have a regular exercise program? ☐ Yes ☐ No

Personal Satisfaction With Diet

☐ Highly Satisfied
☐ Satisfied
☐ Dissatisfied
☐ Highly Dissatisfied

Lifestyle Stress Levels

☐ High ☐ Moderate ☐ Low

Please outline on the diagram the area of your discomfort and any radiation of pain