



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 worst: _____

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: _____

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

- Dizziness
- Forgetfulness
- Convulsions
- Cold / Tingling Extremities
- Obsessive Defiance Disorder
- Obsessive Compulsive Disorder
- Attention Deficit Disorder
- Autism
- Down's Syndrome
- Developmental Disabilities
- Learning Disabilities

- 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

Cardiovascular System

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

Personal Satisfaction With Diet

- Highly Satisfied
- Satisfied
- Dissatisfied
- Highly Dissatisfied

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

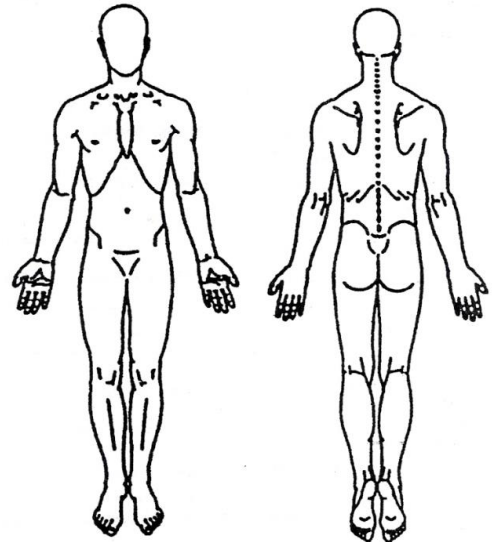
Respiratory System

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

Lifestyle Stress Levels

- High Moderate Low

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



Gastro-Intestinal System

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

General

- Fatigue
- Loss of Sleep
- Fever

Allergies

- Environmental: _____
- Food: _____
- Medications: _____

Nervous System

- Stress Anxiety
- Numbness
- Paralysis

EENT

- Headaches Migraines
- Vision Problems
- Dental Problems
- Sore Throat Stuffed Nose