# NW Chiropractic and Massage

## Chiropractic Intake Form

## PATIENT INFORMATION

**Name:** ____________________ **Alberta Health Care #:** ____________
**Address:** ____________________ **City:** ____________ **Postal Code:** ____________
**Home Phone:** ____________ **Cell Phone:** ____________
**Email:** ____________________
**Date of Birth:** ____________ **Age:** ______ **Sex:** ☐ **Male** ☐ **Female**
**Occupation:** ____________ **Employer:** ____________
**Emergency Contact:** ____________ **Relationship:** ____________ **Phone:** ____________

## MEDICAL INFORMATION

**Family Doctor's Name:** ____________________ **Clinic Name:** ____________________
**Date of Last MD Visit:** ____________ **Date of Last Physical:** ____________
**What Medications Are You Taking?** ____________________
*Do you consent to allow us to contact your medical doctor?* ☐ Yes ☐ No

**Which Other Therapies Have You Received:**
☐ **Chiropractic** ☐ **Massage** ☐ **Physiotherapy** ☐ **Acupuncture** ☐ **Other** ____________

**Which Other Therapies Are You Interested In:**
☐ **Massage** ☐ **Physiotherapy** ☐ **Acupuncture** ☐ **Other** ____________

## HOW DID YOU FIND US?

☐ **Referred by Family / Friend** ☐ **Referred by MD** ☐ **Internet / Website**
☐ **Referred by Trainer** ☐ **Walk In** ☐ **Other** ____________
**Whom May We Thank For The Referral?** ____________________

## CONDITION OR INJURY INFORMATION

**Reason For Your Visit:** ____________________ **When Did This Begin?** ____________
**Have You Had This Before?** ☐ **Yes** ☐ **No** **When?** ____________
**Is It Getting:** ☐ **Worse** ☐ **Better** ☐ **Unchanged**
**Is This Related To:** ☐ **Work Injury** ☐ **Auto Accident**
**Have You Seen Anyone Else For This Condition:** ☐ **Yes** ☐ **No** **Who?** ____________

**What Does Your Pain Feel Like?** (check all that apply)
☐ **Tight and Stiff** ☐ **Dull / Achy** ☐ **Sharp** ☐ **Pins and Needles** ☐ **Numb** ☐ **Burning**
☐ **Other** ____________________

**What Aggravates Your Pain?**
☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Lifting** ☐ **Exercise** ☐ **Weather Change** ☐ **Rest**
☐ **Other** ____________________

**What Relives Your Pain?**
☐ **Rest** ☐ **Movement** ☐ **Ice** ☐ **Heat** ☐ **Medication** ☐ **Other** ____________

## PLEASE RATE YOUR PAIN:

Least Pain **0 1 2 3 4 5 6 7 8 9 10** Most Pain

**Does This Condition Interfere with:** ☐ **Work** ☐ **Family / Social Life** ☐ **Sport / Hobby** ☐ **Sleep**

**What Do You Think Caused This Condition?** ______________________________

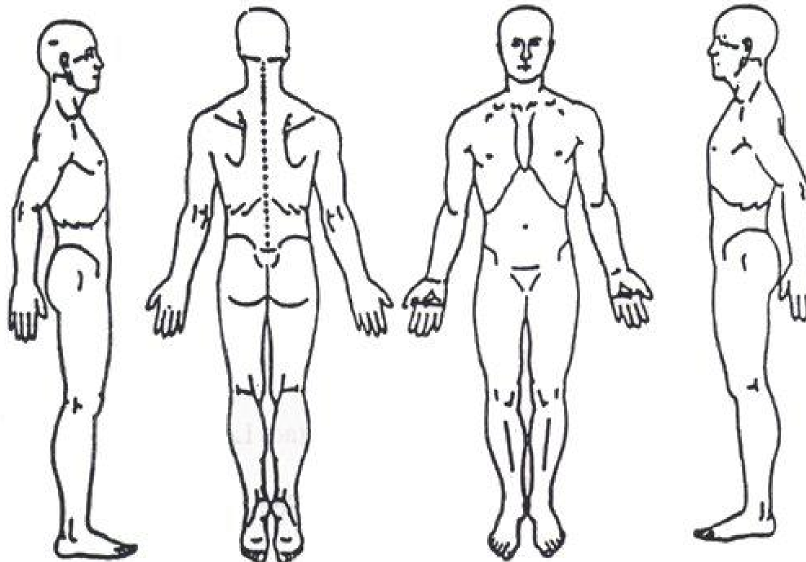
**What Is This Condition Stopping You From Doing?** ______________________________

**Please List Any Secondary Complaints:** ______________________________

______________________________

## PLEASE INDICATE ON THE DIAGRAM THE AREAS YOU FEEL PAIN, TENSION, DISCOMFORT

| Numbness | ==== | Pins/Needles | ~~~~ | Burning | oooo |
|---|---|---|---|---|---|
| Sharp | xxxx | Dull/Achy | ΔΔΔΔ | Stiff/Tight | 2222 |



## HEALTH HISTORY:

**At Any Time In The Past, Have You:**

**Had Surgery:** ☐ Yes ☐ No
**Been Hospitalized:** ☐ Yes ☐ No
**Had a Concussion:** ☐ Yes ☐ No
**Had a Fracture:** ☐ Yes ☐ No
**Been in a Car Accident:** ☐ Yes ☐ No
**Explain The Above:** (When, Where, Why) ____________

**Have You Been Diagnosed With:**

☐ Cancer ☐ HIV / Aids ☐ Hepatitis ☐ Other
☐ High Blood Pressure: ☐ High Cholesterol
☐ Are You Pregnant? Due Date: ____________ # Of Previous Pregnancies: ______
# Of Children: ______
☐ Allergies Please List: ____________

| Is There a Family History Of: | Heart Disease | Stroke | Cancer | Diabetes | Arthritis | Other |
|---|---|---|---|---|---|---|
| Mothers Side: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fathers Side: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## LIFESTYLE:

**Are You Currently a Smoker?** ☐ Yes ☐No
**Were You Ever a Smoker?** ☐ Yes ☐No
**Do You Consume Alcohol?** ☐ Yes ☐No
**Do You Exercise?** ☐ Yes ☐No
**How Often?** ____________

**Rate Your Stress Level:**
☐Extreme ☐High ☐Moderate ☐Low ☐None

## GENERAL HEALTH SURVEY:

### Musculo-Skeletal

☐ Low Back Pain
☐ Mid Back Pain
☐ Neck Pain
☐ Joint Pain
☐ Walking Problem
☐ Clicking Jaw
☐ TMJ Pain
☐ Sciatica
☐ Fibromyalgia
☐ Arthritis
☐ Gout

### Neurological

☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Fainting
☐ Convulsions
☐ Nausea
☐ Loss of Balance
☐ Cold / Tingling Extremities

### Ear/Nose Throat

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Ear Infections
☐ Hearing Problems
☐ Stuffed Nose
☐ Sinus Infections
☐ Ringing in Ears

### Respiratory

☐ Chest Pain
☐ Short Breath
☐ Lung Problems / Congestion
☐ Asthma
☐ Coughing up Blood
☐ Coughing up Phlegm
☐ Chronic Cough

### Cardiovascular

☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Ankle Swelling
☐ Varicose Veins
☐ Chest Pain
☐ Previous Heart Attack
☐ Previous Stroke

### General

☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches
☐ Night Pain
☐ Anxiety
☐ Depression
☐ Fainting
☐ Loss of Weight

### Genito-Urinary

☐ Bladder Problems
☐ Painful / Excessive Urination
☐ Discoloured Urine
☐ Blood in Urine
☐ Menstrual Cramps
☐ Kidney Infection
☐ Irregular / Absent Cycle
☐ Painful Breasts
☐ Prostate Problems

### Gastro-Intestinal

☐ Poor Appetite
☐ Excessive Appetite
☐ Excessive Thirst
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Liver Problems
☐ Bloating
☐ Heartburn
☐ Black / Bloody Stool
☐ Colitis
☐ IBS
☐ Crohn’s