CHIROPRACTIC PATIENT INTAKE FORM

PERSONAL INFORMATION

DATE

☐ MR ☐ MS ☐ DR

FIRST NAME | INT | LAST NAME | HOME PHONE

STREET NUMBER AND NAME | WORK PHONE | EXT

CITY | POSTAL CODE | COUNTRY | CELL PHONE

DATE OF BIRTH (DD MM YY) | AGE | EMERGENCY CONTACT | RELATION | EMERGENCY PHONE

NAME SPOUSE/COMMON LAW | EMAIL

HOW DID YOU HEAR ABOUT US ☐ PHONE BOOK ☐ SIGN ☐ PERSON | OTHER

EMPLOYMENT INFORMATION

EMPLOYER | CAN WE CALL YOU AT WORK ☐ YES ☐ NO

EMPLOYER ADDRESS | EMPLOYER CITY | EMPLOYER P/C

EXTENDED HEALTH CARE INFORMATION

EXTENDED HEALTH CARE COMPANY | GROUP NUMBER | POLICY NUMBER/ID NUMBER

FAMILY PHYSICIAN INFORMATION

FAMILY PHYSICIAN | PHONE NUMBER (IF KNOWN) | CAN WE CONTACT THEM ☐ YES ☐ NO

PREVIOUS CHIROPRACTIC CARE (ONLY COMPLETE IF IT APPLIES)

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO IF YES THEN PLEASE COMPLETE BELOW

NAME OF CHIROPRACTOR

REASONS FOR SEEKING CARE

OFFICE POLICIES

SCHEDULING

Appointments during regular hours must be scheduled to reduce patient waiting time.
Drops in are welcome, however all scheduled appointments will be seen first.
Cancellations require 24 hours notice to make the appointment available to other patients.

PAYMENT

Payment is expected in full each visit, we accept Cash, Cheque, Interac Debit Card, and Visa, etc.
NSF Cheques will be charged a $15.00 fee.
Should you discontinue care for any reason, any outstanding balance will become due immediately and payable in full by you.

FEES

The fee is payable in full at each visit. Patients with health insurance plans, typically part of an employee benefit package, are allowed to claim their patient fee for chiropractic services through their insurer.

PLEASE COMPLETE BELOW

FAMILY HISTORY OF DISEASE	
CANCER	
STROKE	
DIABETES	
HYPERTENSION	
YOUR HISTORY	
ANEURYSM	
STROKE	
EPILEPSY	
HEART	
OSTEOPOROSIS	
BONE	
DIABETES	
CANCER	
BLOOD CLOTS	
BLEEDING	
HIGH/LOW BP	
ARTHRITIS	
NEUROLOGICAL	
DIZZINESS	
HEADACHES	
HIV POSITIVE	
PREGNANCY	
LIFE STYLE	
DO YOU SMOKE	
BIRTH CONTROL	
PLEASE LIST ALL THE SURGERIES YOU HAVE HAD IN THE PAST	
PLEASE LIST ANY MEDICATION/ VITAMINS YOU ARE CURRENTLY TAKING	

PLEASE TURN PAGE OVER

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CHIROPRACTIC PATIENT INTAKE FORM

CHIEF COMPLAINT PLEASE COMPLETE THE FOLLOWING

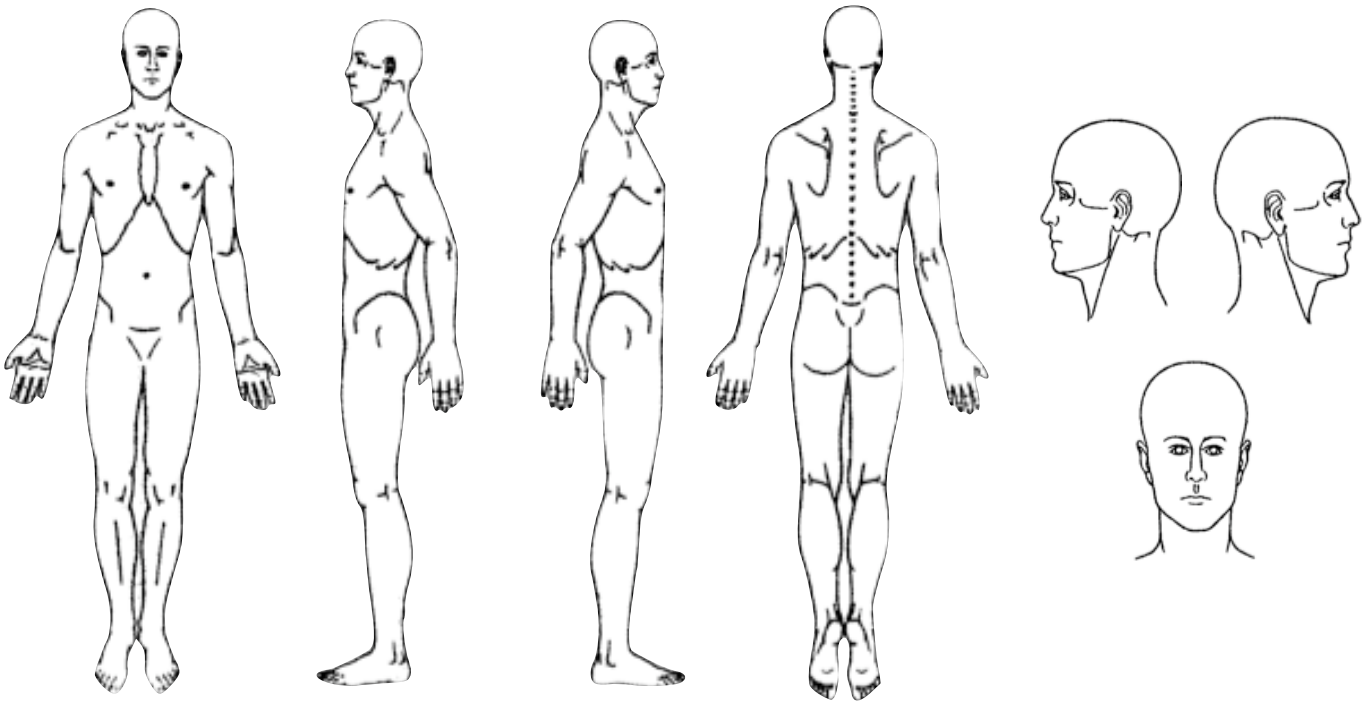
STEP 1

ON THE BODY BELOW, USING THE FOLLOWING SYMBOLS, PLEASE MARK THE LOCATION OF YOUR PRIMARY COMPLAINT

ACHE	BURNING	NUMBNESS	TINGLING	STABBING/ SHARP	DEEP
XXXXX	++++++	^^^^^^	*********	/////////	----------

STEP 2

	HOW DID YOUR SYMPTOMS START?		**WHEN** DID YOUR SYMPTOMS START
	SUDDEN		0-3 MONTHS
	GRADUAL		3-6 MONTHS
	CAR ACCIDENT		6-9 MONTHS
	WORK RELATED INJURY		1 YEAR OR MORE



STEP 3

IF YOUR DISCOMFORT IS PAIN, PLEASE MARK ON THE LINE BELOW, THE LEVEL OF YOUR PAIN.

0 (NO PAIN) WORSE PAIN (10)

ADDITIONAL COMPLAINTS PLEASE LIST BELOW

1	
2	
3	

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