the chiropractic office

Patient Intake Form

Name_____ Date_____

Address_____City, Province _____

Postal Code_____ Date of Birth_____ Age_____ Sex: M/F

H. Phone _____ Cell Phone_____

Email Address:_____ Occupation_____

How did you hear about this clinic?_____

Family Physician Name:_____ Phone # (if known):_____

Symptoms and Present State of Health

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

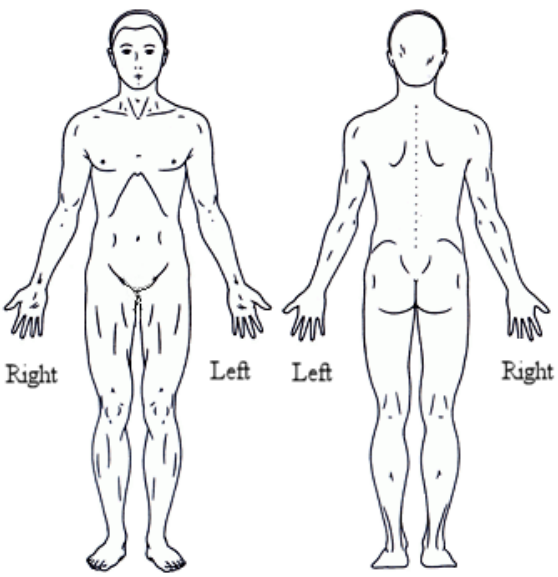
Does this pain shoot, radiate, or travel in your body? Where?_____

Are you experiencing numbness or tingling in any area of your body? Where?_____

Since it began, is it: O Same O Better O Worse

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____



Is this condition worse during certain times of the day?_____

Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.

Clinician Notes:

Patient Past History

Have you been treated for any health condition by a physician in the last year? __ Yes __ No

If yes, explain: _____

Are you currently taking medication? __ Yes __ No list medications: _____

Have you taken medication in the past? __ Yes __ No list medications _____

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions:_____

Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Do you smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day ____

Please mark any of the following conditions or symptoms that you have now or have experienced:

- o Headaches
- o Neck Pain
- o Sleeping Problems
- o Low Back Pain
- o Irritability
- o Nervousness
- o Tension
- o Dizziness
- o Pain Between Shoulders
- o Neck Stiff
- o Joint Swelling
- o Fever
- o Loss of smell or taste
- o Loss of Balance
- o Ringing in Ears
- o Jaw/TMJ Problems
- o Pain in Hands or Arms
- o Numbness in Hands or Arms
- o Pain in Legs or Feet
- o Numbness in Legs or Feet
- o Fatigue
- o Depression
- o Lights Bother Eyes
- o Loss of Memory
- o Sinus
- o Shortness of Breath
- o Asthma
- o Allergies
- o Cold Hands
- o Cold Feet
- o Chest Pains
- o Heart Attack
- o High Blood Pressure
- o Stroke
- o Cancer
- o Painful Urination
- o Weight Loss
- o Menstrual Cramps
- o Menopause
- o Heart Burn/GIRD
- o Diabetes
- o Diarrhea
- o Constipation
- o Stomach Upset

Services and Fees

Initial Visit – Including Assessment & Treatment	90.00	45 minutes
ART ® and/or Acupuncture and Laser Therapy & Adjustment (Extended Visit)	85.00	45 minutes
ART ® & Adjustment	62.50	25 minutes
Acupuncture & Adjustment	62.50	25 minutes
Custom Orthotics	Prices Vary	25 minutes
Student/Children Treatments – please ask		

CANCELLATION POLICY

You may cancel your appointment without charge anytime before the close of business on the business day preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I am aware of the office's cancellation policy and agree to the terms. I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____