Northern Hills Chiropractic & Wellness Centre Patient Intake Form

Name: _____ Date: _____

Address: _____ Postal code: _____

City:_____ Province: _____

Telephone: Home_____ Work_____ Cell _____

If Emergency Call: _____ Name & Relationship:_____

_____

Email Address: _____

Date of Birth (M/D/Y): _____ Age: _____ Gender: M/F

Alberta Health Care number: _____

Occupation: _____

Marital Status: Single Married Divorced Separated Widow Cohabiting

How did you find out about Northern Hills Chiropractic? _____
Is this a medical legal case? If so, name of lawyer? _____
Did the injury happen at work? Yes No

Client Health Information

Present area of concern (where & specifically):

_____
Your symptoms are (circle): increasing not changing decreasing
Have you had any previous treatment for this condition (circle)? Yes No
When did you first notice symptoms? _____

What makes your problem worse? _____
What makes your problem better? _____
Which activities are difficult to perform? **Sitting Standing Walking Bending Laying Down** Other: _____
Type of pain: **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other**: _____
Rate the severity of your pain. (0, no pain to 10, worst pain imaginable) 0 **1 2 3 4 5 6 7 8 9 10**
Is the pain constant or does is come and go? _____

Name of family physician: _____
Names of specialists currently consulting: _____
List all medications you are presently taking? _____
List all supplements/vitamins you are presently taking? _____
List any allergies: _____

Do you bleed or bruise easily? Please check ✓ __Y __N

Are you on anti-coagulant medication? Please check ✓ __Y __N

Please check ✓ any of these professionals you have seen previously.
Chiropractor: ____ Acupuncturist: ____ Massage therapist: ____

Have you been treated for any health condition in the last year? Yes No
If so, please explain: _____
List all major surgeries/operations, any major accidents and falls, and when they occurred:
_____

_____

HEALTH HISTORY: Please check ✓ any of the following conditions that you are currecntly experiencing or have experienced.

General

___Whiplash	___Enlarged glands	___Loss of weight	___Hypoglycemia
___Fertility Problems	___Vision problems	___Hearing problems	___Frequent colds/flu
___Menopause	___Metal Implants	___Pace Maker	___Pregnant
___Nursing	___Birth Control Pills		

Body Systems

___Kidney Disease	___Painful urination	___Blood in urine	___Kidney stones
___Prostate problems	___Anemia	___Hypothyroid	___Hyperthyroid
___Gas/Bloating	___Constipation	___Diarrhea	___Colitis
___Hemorrhoids	___Liver trouble	___Gall bladder trouble	___Eczema
___Psoriasis	___Varicose veins	___Heart Disease	___Shortness of breath
___Asthma	___Depression	___Diabetes	___Hepatitis
___Cancer	___Epilepsy/Seizures	___Stroke	___PMS
___Black/bloody stool			

Musculoskeletal System

___Low back pain	___Neck pain	___Arm pain	___Shoulder pain
___Elbow pain	___Wrist pain	___Leg pain	___Knee pain
___Foot pain	___Clicking jaw	___Walking problems	___Ankle swelling
___Scoliosis	___Arthritis	___Tingling/numbness	___Painful tailbone
___Pain b/w the shoulders	___Difficulty chewing	___Osteoporosis	___Gout

Nervous System

___Vertigo	___Dizziness	___Fainting	___Headaches
___Ringing in the Ears	___Confusion	___Depression	___Loss of feeling

Check ✓ any that you have experienced:

___Alcoholism	___Arthritis	___Hypoglycemia	___Cancer
___Allergies	___Diabetes	___Rheumatic fever	___Heart disease
___High/Low blood pressure			

Has anyone in your family had any of the following?

___Heart disease	___Cancer	___High blood pressure
___Stroke	___Arthritis	___Diabetes

How many times per week do you exercise? _____
How many hours of sleep do you get per night? _____
How much alcohol do you consume (circle)? None Light Moderate Heavy
How much tobacco do you consume (circle)? None Light Moderate Heavy
How stressed are you (circle)? None Light Moderate Heavy
What are your health goals? _____
How many glasses of water do you drink per day? _____ glasses.