High St. Chiropractic - New Patient Intake Form

Date:

Patient Information:

Name _____

Date of Birth _____ Age _____ Sex M / F

Mailing Address _____

_____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Occupation: _____

Emergency Contact _____

Phone # _____

How did you hear about this office? _____

Whom may we thank for referring you? _____

_____

Email: _____

May we add you to our e-mail list for periodic news, articles and updates? Yes / No

Previous Health Care:

Have you had previous chiropractic care? Yes / No

Provider's Name _____

When/Why? _____

Medical Doctor:

Name _____

Address/ Phone # _____

Date of last physical exam: _____

Did your medical doctor recommend that you seek chiropractic care? Yes / No

May we communicate with your medical doctor regarding your health condition? Yes / No

Have you recently had x-rays or imaging? Yes / No

Date & Location: _____

Chief Complaint:

Primary Complaint _____

_____

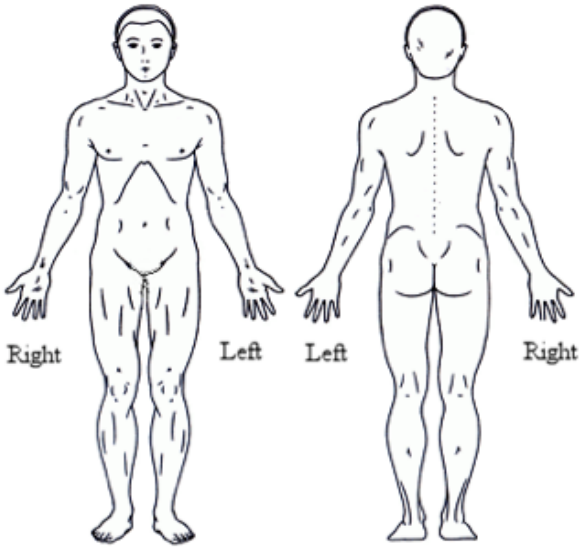
_____

Other Complaints _____

_____

Is this condition due to a motor vehicle accident? Y / N

Please mark all problem areas appropriately:



Sharp /// Burning XXX Dull Ache OOO

Pins/Needles +++ Numbness •••

Please circle the degree of pain (0=None, 10=Extreme)

0 1 2 3 4 5 6 7 8 9 10

Did the problem come on: ☐ Suddenly ☐ Slowly

When and how did this problem begin _____

_____

_____

_____

Have you had a similar condition before? Yes / No

If yes, when? _____

Is the pain: ☐ Improving ☐ Unchanging ☐ Worsening

Is the pain: ☐ Constant ☐ Intermittent

When does it bother you most? _____

_____

What makes this condition better? _____

_____

What makes this condition worse? _____

_____

Does the pain radiate anywhere? If so, where? _____

_____

What treatments, medications, etc have you tried using for this condition? Did they work? _____

_____

Does this condition interfere with: ☐ Sleep ☐ Work ☐ Home life ☐ Daily Routine ☐ Recreation/exercise

Is there anything else that you think is relevant or important regarding your condition? _____

_____

_____

_____

79 High St., Barrie, ON L4N 1W5
P: (705) 721-1611 F: (705) 721-5710

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Name:

Date:

Please list any previous injuries, falls, motor vehicle accidents, hospitalizations or surgeries: _____

Please list any medications that you are currently taking or have taken recently_____

Social History/Habits

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

...If yes, how long have you smoked for? _____

Work Activities

Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

Health History - Please check off any of the following that **you** currently have or have had in the past (indicate age diagnosed):

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Vision problems
- ☐ Weight loss/gain

Muscle/ Joint
- ☐ Arthritis
- ☐ Weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Other joint pain

Skin
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye/Ear/Nose/Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis/ Crohn's disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestion problems
- ☐ Diverticulosis
- ☐ Bloating
- ☐ Gallbladder problems
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver disease
- ☐ Nausea
- ☐ Painful defecation
- ☐ Vomiting of blood

Genitourinary
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Atherosclerosis
- ☐ Chest pain
- ☐ Heart palpitation
- ☐ Poor circulation

Respiratory
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Spitting up phlegm/blood
- ☐ Wheezing

Women Only
- ☐ Breast disease
- ☐ Vaginal discharge
- ☐ Menopause

Are you currently pregnant?
☐ Yes ☐ No
If yes, how many weeks: _____
Number of children: _____
Date of last pap test:_____
☐Normal ☐Abnormal

Men Only

Have you ever had a prostate exam? ☐ Yes ☐ No
Date of last exam:_____

Health History – Please check any conditions that you have or have had and indicate the age at which you were diagnosed:

☐ Alcoholism	☐ Anemia	☐ Appendicitis	☐ Arteriosclerosis	☐ Asthma
☐ Bronchitis	☐ Cancer	☐ Diabetes	☐ Edema	☐ Emphysema
☐ Epilepsy	☐ Goiter	☐ Gout	☐ Heartburn	☐ Heart disease
☐ Hepatitis	☐ High cholesterol	☐ HIV/AIDS	☐ Miscarriage	☐ Multiple sclerosis
☐ Neurological disorder	☐ Pace maker	☐ Osteoporosis	☐ Pneumonia	☐ Polio
☐ Rheumatic fever	☐ Stroke	☐ Thyroid disease	☐ Ulcers	☐ Other _____

Family History – If any **blood relative** has had any of the following conditions, please check and indicate which relative:

☐ Arthritis	☐ Autoimmune Disease	☐ Bleeding Disorder
☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Stroke	☐ Thyroid Disease