DALHOUSIE FAMILY CHIROPRACTIC

Patient Intake Form

Complete this brief questionnaire and health history form to help us get to know you. Dr. Smuszko will use this information to help formulate the recommendations for your care.

Alberta Health #:

PATIENT DEMOGRAPHICS

Name____ Male / Female Date: ______________________

Address: _____________________________________ City: ___________________________ Prov: ______ Postal Code: ________________

Home Phone #: ________________________Cell Phone #: ________________________ Business #: ______________________________

E-mail: ____ By providing your email address you consent to receive correspondence about appointment times and events at the clinic.

Date of Birth: MM / DD / YY Age: ______ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐

Names and Ages of Children: ____

Whom may we thank for referring you to our office? ____

Employer: ____ Occupation: ____

Name of Emergency Contact: ________________________ Phone Number: _____________________ Relationship: _________________

HISTORY OF COMPLAINT

Please identify the complaints that have brought you to our office:

Primary: ____

Secondary: ____

Third: ____

On the scale of **0** to **10 (**10 being the worst pain) rate your above complaints by **circling the number:**

Primary or chief complaint: 0 1 2 3 4 5 6 7 8 9 10

Secondary complaint: 0 1 2 3 4 5 6 7 8 9 10

Third complaint: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? ____________________________

When is the problem at its worst? (circle one) AM / mid-day / late PM

How long does it last? (i.e. Constant, comes and goes, on and off etc.)

____

Is this injury work related? (circle one) YES / NO

How did the injury happen? ___________________________________

For Office Use Only:

Have the condition(s) ever been treated by anyone in the past? (circle one) YES / NO

If **yes**, when? _____________ By whom? __________________________________ How long were you under care? _________________

What relieves your symptoms? ____

What makes them feel worse? ____

Dr. Jerry Smuszko
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PAST HEALTH

Have you ever suffered from any of the following conditions? Circle yes or no

Thyroid trouble.............. Y N	Tuberculosis.......... Y N	Emotional Problems... Y N	Psoriasis...................... Y N
Diabetes.......................... Y N	Pneumonia............ Y N	Epileptic seizures........ Y N	Polio............................. Y N
High blood pressure...... Y N	Back pain............... Y N	Asthma......................... Y N	Cancer.......................... Y N
Heart disease................. Y N	Headaches............ Y N	Arthritis........................ Y N	Venereal disease........ Y N
Allergies.......................... Y N	Stomach ulcers.... Y N	Alcoholism.................... Y N	HIV............................... Y N

Please list any significant illness, operations, accidents, falls or traumas:

Date	Illness/Operation/Accident/Falls

PRESENT HEALTH

Are you presently affected by any of the following? (past 12 months)

Please circle: **O** – Occasional **F** – Frequent **C** – Constant **Y** – Yes **N** – No

Stress Symptoms
- Headache/Migraine..........O F C
- Dizziness..........O F C
- Numbness..........O F C
- Ringing in ears..........O F C
- Blurring of vision..........O F C
- Loss of sleep..........O F C
- Loss of concentration..........O F C
- Irritable/nervousness..........O F C
- Depression..........O F C
- Decreased energy..........O F C
- Tension..........O F C

Gastrointestinal
- Difficult digestion..........O F C
- Belching or gas..........O F C
- Nausea/vomiting..........O F C
- Pain over stomach..........O F C
- Constipation..........O F C
- Colon trouble..........O F C
- Liver trouble..........O F C
- Gall bladder trouble..........O F C
- Heartburn..........O F C
- Diarrhea..........O F C
- Bloody stools..........O F C

General Symptoms
- Fever/chills/sweat..........O F C
- Fainting..........O F C
- Convulsions..........O F C
- Allergies..........O F C
- Skin problems..........O F C
- Colds..........O F C
- Tremors..........O F C
- Loss of balance..........O F C

Muscle and Joint
- Backache..........O F C
- Neck pain..........O F C
- Painful tailbone..........O F C
- Foot trouble..........O F C
- Shoulder pain..........O F C
- Hernia..........O F C
- Spinal curvature..........O F C
- Faulty posture..........O F C
- Arthritis..........O F C

Respiratory
- Chronic cough..........O F C
- Spitting up..........O F C
- Chest pain..........O F C
- Difficult breathing..........O F C

Urinary
- Painful urination..........O F C
- Getting up at night to pee..........O F C
- Blood in urine..........O F C
- Increased urination..........O F C

Eyes, Ears, Nose and Throat
- Deafness..........O F C
- Earache..........O F C
- Sore throat..........O F C
- Asthma..........O F C
- Tonsillitis..........O F C
- Sinus trouble..........O F C

Cardiovascular
- Rapid heartbeat..........O F C
- Slow heart beat..........O F C
- High blood pressure..........O F C
- Low blood pressure..........O F C
- Pain over heart..........O F C
- Swelling of ankles..........O F C
- Previous heart attack..........Y N
- Poor circulation..........Y N
- Previous stroke..........Y N

Females Only
- Painful menstruation..........Y N
- Irregular..........Y N
- Cramps or backache..........Y N
- Abnormal discharge..........Y N
- Passed menopause..........Y N
- Birth Control Pill ....Y N
- Are you pregnant?..........Y N
- # of miscarriages __________
- Date of last period __________

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