CHIROPRACTIC INTAKE & HISTORY

loving life chiropractic

PATIENT INFORMATION

Date DD/MON/YY

Patient Name ____________________
FIRST NAME
LAST NAME MIDDLE INITIAL

Address ____________________

City __________ Post Code __________ Prov ______

Home Phone ____________________

Cell Phone ____________________

Email ____________________

Sex ❑ M ❑ F Age ______ Birthday DD/MON/YY

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Common Law / Partner

Employer / School ____________________

Occupation ____________________

Partner's Name ____________________

Partner's Employer ____________________

Partner's Occupation ____________________

YOUR HEALTHCARE PROVIDERS

GP __________ Last Seen __________ For ________

Chiro __________ Last Seen __________ For ________

Other __________ Last Seen __________ For ________

Who may we thank for referring you? ____________________

HOW CAN WE HELP YOU?

What brings you in today? ____________________

If you are already experiencing a symptom, what is it? ____________________

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please indicate main area of discomfort on diagram:

Sharp pain = #####

Dull ache = XXXX

Numbness/tingling = OOOO

Other = ++++ = (Please specify sensation) __________

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Recreation	❑	❑	❑	❑
Relationships	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑
Energy	❑	❑	❑	❑
Attitude	❑	❑	❑	❑
Patience	❑	❑	❑	❑
Productivity	❑	❑	❑	❑
Creativity	❑	❑	❑	❑
Other __________	❑	❑	❑	❑

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? ____________________

B. In what direction is your health currently headed? ____________________

What are your health goals?

IMMEDIATE ____________________

SHORT TERM ____________________

LONG TERM ____________________

CHILDREN & PREGNANCY

How many children do you have? ____________________

Children's ages? ____________________

Children's names? ____________________

Are you currently pregnant? ❑ No ❑ Yes, I am due __________

Number of past pregnancies? ____________________

Health concerns regarding this pregnancy? ____________________

HEALTH & ILLNESS HISTORY

Tick ☑ for current condition. Cross ☒ for past condition. Blank □ for never.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other ____________________

HEALTH & ILLNESS HISTORY (continued)

For each tick ☑ above complete one line below.

Current condition	Date first noticed DD/MON/YY	Cause?	Frequency per dy/wk/mth "c" = constant	Other remarks

(continue on blank paper if necessary)

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list) ______________________________

____

____

MEDICATIONS (list) ______________________________

____

____

SUPPLEMENTS (list) ______________________________

____

____

LIFESTYLE HABITS

Indicate number in boxes below

On average approx how many...

a)...glasses wine, beer, alcohol/ week? ☐ glasses. b)...cigarettes / day? ☐ cigarettes. c)...medical pills / day? ☐ pills.

d)...supplement pills / day? ☐ pills. e)...hrs sleep / day? ☐ hours . f)...sessions of intense exercise / wk? ☐ sessions.

g)... meals/snacks with fresh vegetables/fruit per day? ☐ meals. h)...glasses water / day? ☐ glasses.

FAMILY HEALTH PROFILE

Main Family Health Conditions

Children ______________________________

Spouse ______________________________

Mother ______________________________ Father ______________________________

Brother ______________________________ Sister ______________________________

Thank you for carefully completing ALL the sections of your intake form. This helps you better achieve your health goals and it helps us make the best descisions for your care. Please carefully read and sign the consent form below.

CONSENT FOR CHIROPRACTIC CARE

Extensive, prolonged, studies have show that qualified, well-trained chiropractors provide an extremely safe form of care.

Ethically, before starting your care, we need you to be informed of any risks so please read the following carefully.

Occasionally people under care experience mild healing effects and reactions such as muscle stiffness, local tenderness, tiredness, headaches, "flu-type" symptoms, release of emotions (such as crying) or dizziness. On very rare occasions 1 in 10,000 people report rib fracture. Whilst often reported anecdotally, serious injuries such as stroke are so extremely rare that they are reported as being less than 1 stroke per 2 million cervical adjustments. To put this into perspective, hospitalisations from the mildest of medical intervention such as a use of anti-inflammatory medications (e.g. Ibuprofen™) are estimated at 40,000 per million (i.e. 80,000 times more likely) and deaths at 4000 per million (i.e. 8,000 times more likely), respectively.

In other words, receiving 80,000 adjustments has an equal risk to taking 1 ibuprofen pill.

I give consent to receive a chiropractic assessment which may include a non-intrusive thermal scan and a full hands-on examination at this practice.

If deemed appropriate by the Chiropractic Doctor I consent to receiving chiropractic adjustive care.

Signed:______________________________ Date:(DD/MON/YY)______________

Dr Craig Hindson & Dr Marie-Claude Lambert
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