HANDS ON HEALTH
FAMILY CHIROPRACTIC

Welcome to Hands on Health Family Chiropractic!

Please fill out this form completely and accurately, to the best of your ability.
All the information requested below is necessary for us to serve you in the best way possible**.**

Today's Date: _____

ADULT INTAKE FORM

PERSONAL INFORMATION:

Name_____
Age _____ Gender: Male __ Female __ Date of Birth (dd/mm/yyyy)_____
Home Address_____
City _____ Prov____ Postal Code _____ Cell phone (____) _____
E-mail address _____
Business Phone (____) _____Home Phone(____)_____
Occupation_____Employer_____
Work Status Full Time Part Time Disability Student Retired Unemployed
Annual health insurance coverage for chiropractic: _____ Orthotics: _____
Marital Status S M Partner D W Name of Spouse/Partner_____
Names and Ages of Children_____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE:

Please describe why you have come to Hands on Health Family Chiropractic today.

_____
_____
_____

What are your three main health goals/concerns (can include any goal from any category - nutrition, exercise, wellness, mental health, lifestyle, sleep, etc)?

_____
_____
_____

HEALTH CARE PRACTITIONER HISTORY:

Previous Chiropractor? __Yes __No Name _____
What City/Town? _____Date of last visit?(mm/yy)_____
Health Concern? _____
Name of Medical Doctor _____
Phone _____Date of last visit? (mm/yy)_____

Dr. Stacey Farquhar, DC Dr. Matthew Garofolo, DC Dr. Brian Wolfs, DC
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TRAUMA HISTORY:

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips? ___Yes ___No
Please Explain:_____

Have you ever broken any bones or sprained any part of your body? ___Yes ___No
Please Explain:_____

Have you ever been hospitalized or had any previous surgeries? ___Yes ___No
Please Explain:_____

Have you ever been in a Motor Vehicle Accident? ___Yes ___No

Date: (dd/mm/yy) _____
Desription of accident:
_____
_____
Injured: _____
Physical Exam by: _____
Received Treatment by: _____

Date: (dd/mm/yy) _____
Desription of accident:
_____
_____
Injured: _____
Physical Exam by: _____
Received Treatment by: _____

Please list all medications (prescribed or over the counter):
_____
_____

Please list all current Supplementation/Vitamins
_____
_____

How stressed do you feel on a scale of 0-10 (0 = completely stress free, 10 = out of control)
Professional?_____ Personal?_____

How Happy do you feel on scale of 0-10 (0=depressed, 10 = joyful)
Professional?_____ Personal?_____

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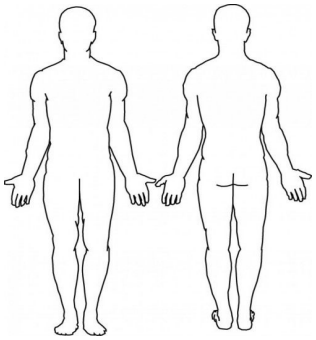
The following questions apply to the major concern that you have come in for.

Where is the location of your major complaint?

Front Rear  Write any notes in margins	X = Pain → = Radiates/Travels ☐ Burning ☐ Stabbing ☐ Sharp ☐ Diffuse ☐ Tingling ☐ Numb ☐ Shooting ☐ Dull Aching ☐ Sore ☐ Other _____

Spinal stress can put pressure on and off the spinal cord and nerves causing symptoms to come and go over time. Is your condition **CONSTANT** or **INTERMITTANT**? (Circle One)

Circle on a scale of 1-10 how you would rate your discomfort:

No Pain Moderate Pain Extreme Pain
0 1 2 3 4 5 6 7 8 9 10

What have you found that **aggravates** your symptoms?

_____

What have you found that **relieves** your symptoms?

_____

Who have you **already seen** in an attempt to correct this problem? (ex. Chiropractors, Physiotherapists)

_____

How has it affected your life? What are you hoping to improve in your life with Chiropractic care? That is, what would you like to **start doing** or **do more of** if you are feeling 100%?

_____

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How **committed** are you to achieving **optimal health?**

No interest Moderately committed 100% Committed
0 1 2 3 4 5 6 7 8 9 10

Do you smoke cigarettes on a daily basis? __Yes __No
How many per day, on average? _____ For how long? _____
What type of exercise do you currently partake in?_____
Days per week?_____ Hours at a time?_____
What type would you like to partake in?_____
When was the last time you would consider yourself fit?_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, repetitive stressors and events occur which damage your health expression. This case history will help uncover the layers of damage, especially to your nerve system, that have resulted from your lowered state of health. At your report of findings, the doctors will outline a course of care to correct these layers of damage and recover your innate health potential.

Past Health: Have you ever suffered from any of the following conditions?

	Yes	No		Yes	No		Yes	No
Thyroid Trouble			Tuberculosis			Emotional Problems		
Diabetes			Pneumonia			Epileptic Seizures		
High Blood Pressure			Back Pain			Asthma		
Heart Disease			Headaches			Arthritis		
Allergies			Stomach Ulcers			Alcoholism		
Psoriasis			Polio			Cancer		
Venereal Disease			HIV			Stroke		

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Present Health: Are you presently affected by any of the following? (Within the past 3 months)											
Please check the boxes: O - Occasional F - Frequent C - Constant											
MUSCLE & JOINT	**O**	**F**	**C**	**Eyes, Ears, Nose, Throat**	**O**	**F**	**C**	**GASTROINTESTINAL**	**O**	**F**	**C**
Neck Pain				Asthma				Indigestion			
Shoulder Pain				Sinus Trouble				Gas Pains			
Low Back Pain				Tonsillitis				Nausea or Vomiting			
Knee Trouble				Sore Throat				Stomach Pains			
Foot Trouble				Earache				Constipation			
Arthritis				Deafness				Heartburn			
Hernia								Diarrhea			
Spinal Curvature				**STRESS SYMPTOMS**				Colon trouble			
Faulty Posture				Headache				Liver trouble			
Sciatica				Migraines				Bladder trouble			
Painful Tailbone				Dizziness				Kidney trouble			
				Numbness or pins & needles in arms/hands, legs/feet				Bloody stools			
CARDIOVASCULAR				Ringing in ears							
Rapid heart beat				Blurring of vision				**URINARY**			
High blood pressure				Loss of sleep				Painful urination			
Low blood pressure				Loss of concentration				Waking at night to urinate			
Pain over heart				Loss of memory				Increased urination			
Swelling of ankles				Irritable/nervousness				Blood in urine			
Poor circulation				Depression							
				Decreased energy/fatigue				**FEMALES**			
GENERAL SYMPTOMS				Tension				Painful menstruation			

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Fever/chills/sweating								Irregular periods				
Fainting				**RESPIRATORY**				Passed menopause				
Convulsions				Chronic Cough				Menopausal symptoms				
Allergy				Spitting up phlegm/blood				Birth control pills				
Skin problems				Chest pain				**Are you pregnant?** Yes No				
Colds				Difficulty breathing				**Date of last menstruation:**				
Tremors								(ddmmyy) _____				
Loss of balance												

FINANCIAL INFORMATION

Payment in full is expected on all first visit services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. We accept Visa, Mastercard, Interac, AMEX, Cash or Cheque.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. You are responsible for payment of all services at the time of service. We will gladly supply detailed receipts for you to submit to your insurance company for reimbursement.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctors at Hands on Health Family Chiropractic permission to examine me and render care to me today, if mutually agreed upon.

Name (Please Print) :_____
Signature_____ Today's Date_____

Thank you for choosing Hands on Health Family Chiropractic.
We look forward to helping you develop a healthier spine and nerve system.