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# CHIROPRACTIC INTAKE FORM

**DATE:** ____________________

## PATIENT INFORMATION

________________________________________ ______ _____ ___________________
Name Sex: M/F Age Date of Birth (DD/MM/YY)

_____________________________________________________________________________
Address (Street, City, Postal Code)

____________________ ___________________ ____________________
Phone # (Home) Phone # (Work) Phone # (Cell)

MAY WE SEND YOU EDUCATIONAL NEWS OR CLINIC PROMOTIONS VIA E-MAIL? Yes / No

_____________________________________________________
Email Address

_____________________________________________________
Emergency Contact (Name & Phone)

MARITAL STATUS: Single / Married / Divorced / Widowed / Separated

OCCUPATION:____________________________ EMPLOYER:__________________________

SPOUSE'S NAME: _________________________ OCCUPATION:________________________

DO YOU HAVE CHILDREN? Yes / No IF YES, WHAT AGE(S)? _______________________

FAMILY PHYSICIAN: _______________________ CITY:_____________ PHONE:____________

REFERRALS ARE OUR HIGHEST COMPLIMENT. PLEASE SHARE HOW YOU HEARD ABOUT US?
____flyer ____ facebook
____newspaper ____ google
____website ____ one of our patients (who? ______________________________)
____sign ____referral from doctor (which doctor? _________________________)
____other (please explain:___________________________________)

DO YOU HAVE EXTENDED HEALTH COVERAGE? Yes / No
INSURANCE COMPANY:_______________________________ AMOUNT ELIGIBLE $ _______

IS THIS CONDITION DUE TO AN ACCIDENT? Yes / No DATE OF ACCIDENT: _____________

TYPE OF ACCIDENT: Auto / Work / Home / Other: ___________________________________

## PATIENT CONDITION

ARE YOU PREGNANT? Yes / No HOW FAR ALONG? ___________ 1st PREGNANCY? Yes / No

REASONS/COMPLAINTS FOR SEEKING CHIROPRACTIC CARE:

Primary reason: ____________________________________________________________________

Secondary reason: _________________________________________________________________

Other reasons: ____________________________________________________________________

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? Yes / No WHO? _____________________
CITY? ____________________________ DATE OF LAST VISIT? ___________________________
FOR WHAT COMPLAINT(S)? ________________________________________________________
COMPLAINT RESOLVED? Yes / No / Somewhat

HAVE YOU HAD X-RAYS TAKEN IN THE PAST 5 YEARS? Yes / No
OF WHAT AREA(S)? _____________________________

DO YOU WEAR CUSTOM-MADE ORTHOTICS OR FOOTWEAR? Yes / No

HAVE YOU BEEN TO ANY OTHER HEALTHCARE PRACTITIONER FOR YOUR *CURRENT* COMPLAINT?
YES / NO WHO?_________________________ PROFESSION?______________

WHEN DID THIS CONDITION BEGIN? ____________________ OCCURRED BEFORE? Yes / No

WHAT AGGRAVATES YOUR CONDITION(S)?

| | |
|---|---|
| ____Sitting | ____Walking |
| ____Standing | ____Sleeping |
| ____Bending | ____Weather |
| ____Lifting | ____Other (Please explain: ________________________________________) |

WHAT RELIEVES YOUR CONDITION(S)?

| | |
|---|---|
| ____Ice | ____Bed Rest |
| ____Heat | ____Walking |
| ____Massage | ____Medications (Which? ___________________________________) |
| ____Stretches & exercise | ____Other (Please explain: ________________________________) |

IS IT GETTING: Better / Worse / Constant / Comes and goes

IS THE PAIN:

| | |
|---|---|
| ____Sharp | ____Shooting |
| ____Dull | ____Burning |
| ____Numb | ____Throbbing |
| ____Tingling | ____Stiff |
| ____Aching | ____Other (Please explain: ________________________________________) |

ON A SCALE of 1-10 PLEASE CIRCLE THE SEVERITY OF YOUR PAIN:

No Pain < 0 1 2 3 4 5 6 7 8 9 10 > Severe Pain

## HEALTH INFORMATION

HEIGHT: _______________ WEIGHT: ______________ BLOOD PRESSURE: ________________

DATE OF LAST MEDICAL CHECKUP: ___________________ BLOODWORK: ________________

DO YOU *CURRENTLY* SUFFER FROM ANY DIAGNOSED MEDICAL CONDITIONS? Yes / No

____Diabetes (Which type? ________________________________________)
____Heart Condition (Specifically: ___________________________________)
____Hypertension / Hypotension (Last Record: ___________________ mmHg)
____Cancer (Specifically: _____________________________________________)
____Respiratory Condition (Specifically: _______________________________)
____Gastrointestinal Condition (Specifically: ____________________________)
____Reproductive Condition (Specifically: ______________________________)
____Nervous System Disorder (Specifically: ____________________________)
____Musculoskeletal Condition (Specifically: ____________________________)
____Skin Condition (Specifically: _____________________________________)

HOW LONG HAVE YOU HAD ANY OF THE CONDITIONS LISTED ABOVE? ___________________

ARE YOU CURRENTLY ON ANY MEDICATIONS (over-the-counter or prescribed)? Yes / No
IF YES, WHICH ONE(S)?
_____________________________________________________________________________
_____________________________________________________________________________

ARE YOU CURRENTLY TAKING ANY NATURAL SUPPLEMENTS/HERBAL REMEDIES? Yes / No
IF YES, WHICH ONE(S)?
_____________________________________________________________________________
_____________________________________________________________________________

ARE YOU A SMOKER? Yes / No HOW MANY YEARS? _____ # OF CIGARETTES/DAY? _____

ANY PROLONGED EXPOSURE TO SECOND-HAND SMOKE, CHEMICALS, OR TOXIC MATERIALS? Yes / No

DO YOU CONSUME ALCOHOL? Yes / No # OF ALCOHOLIC DRINKS PER WEEK?________
DO YOU CONSUME CAFFEINE? Yes / No # OF CAFFEINATED DRINKS PER DAY? ______

DO YOU CONSUME ANY OTHER SUBSTANCES? IF YES, WHICH? ________________________

HAVE YOU HAD ANY SURGERY? IF YES, WHAT KIND & WHEN?
_____________________________________________________________________________
_____________________________________________________________________________

PLEASE LIST ALL MEDICAL CONDITIONS THAT APPEAR IN YOUR FAMILY HISTORY AND IN WHOM:
_____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
________________________________________________________________

**Please ☑ checkmark conditions that you currently have and ☒ any conditions you have had in the past.**

**Musculoskeletal**
___Low back pain
___Pain between shoulders
___Neck pain
___Headaches
___Arm pain
___Leg pain
___Joint pain/stiffness
___Swelling
___Jaw pain/clicking
___Arthritis
___Osteoporosis

**Nervous system**
___Numbness in arm/hand
___Numbness in leg/foot
___Paralysis
___Dizziness
___Forgetfulness
___Anxiety
___Depression
___Fainting
___Convulsions

**Cardiovascular / Respiratory**
___Cold hands/feet
___Bruise easily
___Blood disorder
___Chest pain
___Shortness of breath
___High blood pressure
___Irregular heartbeat
___Heart problems
___Pneumonia
___Bronchitis
___Asthma
___Stroke

**Eyes / Ears / Nose / Throat**
___Vision problems
___Loss of smell
___Dental problems
___Sore throat
___Earache/ infection
___Hearing loss
___Ringing in ears
___Sinus congestion

**Gastro-Intestinal**
___Poor appetite
___Excessive thirst
___Frequent nausea
___Diarrhea
___Constipation
___Bloating/Gas
___Abdominal cramps
___Heartburn
___Liver problems
___Bladder problems
___Kidney problems
___Painful/excess urination

**Male / Female Reproductive**
___Prostate problems
___Menstrual pain/cramps
___PMS
___Menstrual cycle irregularity
___Endometriosis
___Back pain with menstrual.cycle
___Menopause
___Breast pain / lumps
___Fibroids / cysts
___Infertility
___Miscarriage
___Difficult delivery of baby

**General**
___Fatigue
___Irritability
___Allergies
___Poor sleep
___Poor balance
___Poor concentration
___High stress
___Weight loss
___Weight gain
___Fever
___Frequent colds

**Other**
________________
________________
________________
________________
________________
________________
________________

IS THERE ANYTHING ELSE YOU WISH TO TELL US? ______________________________________
______________________________________________________________________
______________________________________________________________________

I HEREBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND <u>IT IS MY RESPONSIBILITY TO INFORM THE CHIROPRACTOR OF ANY CHANGES IN MY HEALTH</u>.
*FEMALES:* SHOULD YOU BECOME PREGNANT, OR SUSPECT YOU COULD BE PREGNANT, PLEASE <u>IMMEDIATELY</u> <u>NOTIFY</u> THE CHIROPRACTOR AS SOME THERAPIES MAY BE CONTRAINDICATED TO THE DEVELOPING FETUS.
I AGREE TO ALLOW THE CHIROPRACTOR TO ASSESS ME FOR FURTHER EXAMINATION.

PATIENT NAME: ________________________________________ DATE: ______________________

PATIENT SIGNATURE: ___________________________________

DOCTOR'S SIGNATURE: _________________________________

## Natura Wellness Chiropractic Policies

In order for you to achieve optimal outcomes from Chiropractic, it is expected that you attend as recommended by your practitioner. Please see our policy list below:

1. Please provide 24 hours notice of cancellation for your appointment. A fee of $40 will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.

2. Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities to serve all patients in a fair manner.

3. Payment is due in full at the end of each treatment session. Payments will be accepted by cash, debit, or credit card, and a receipt will be provided for reimbursement by your insurance company after each visit.

**Private Fees as follows:** $125 Initial Assessment
$45 Express Subsequent Visit
$85 Extended Subsequent Visit
$80 Re-evaluation of care & Follow-up treatment*
*After 24 visits or as required by the Chiropractic guidelines set out by the CCO.

I understand and agree with the policies as above:

_______________________________ _______________________

Patient Signature Date