New Patient Intake Form

Name_____ Birth Date (D/M/Y) _____ Age_____
Address _____ Postal code _____
Alberta Health Care # _____ Gender M / F
Marital Status _____ Name of Spouse _____# children____
Phone Number (H) _____ (W) _____
Email Address _____
Occupation_____ Employer _____
Height _____ Weight _____Hobbies_____
How did you hear about our clinic?_____

Chiropractic Information

Have you been to a chiropractor? Y / N Chiropractor's Name _____
What were you treated for? _____ x-rays taken? Y/N
What is bothering you now?_____
How long have you had this condition? _____Is it getting worse? Y/N
Have you had a similar condition in the past? Y/N When?_____
What aggravates this condition?_____
What improves this condition?_____
What aspects of daily life does this condition affect?_____
How do you sleep? □on back □on side □on stomach □combination

Medical Information

Medical Doctor_____ Date of last physical_____
Please list any surgical operations: Year of surgery
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever been in a car accident? Y/ N Date_____
Any other accidents, injuries, broken bones etc.? Y/ N
□ past year □ past 5 years □ over 5 years
Please describe above traumas briefly _____
_____
List any allergies you have _____
Please list **all** vitamins and medications you are on _____
_____
What are these medications for? □ arthritis □ muscle relaxants □ pain killers
□ other (please describe) _____

Please answer the following questions carefully, as these various conditions can affect the overall course of your chiropractic treatment.

Check any of the following conditions you have **ever** had:

□appendicitis □pneumonia □rheumatic fever □polio
□tuberculosis □anemia □diabetes □cancer
□malaria □pleurisy □arthritis □goiter
□epilepsy □alcoholism □psoriasis □eczema
□Mental disorder □venereal disease □thyroid (hypo/hyper)

Check any of the following which you have had in the **last 6 months**:

Musculo-skeletal

□low back pain □mid back pain □neck pain □arm pain
□joint stiffness □jaw pain □leg pain □walking problems

Nervous System

□numbness □paralysis □dizziness □confusion/depression □nervous
□stress □forgetful □fainting □cold/tingling extremities □seizures

Gastro-Intestinal

□poor/excessive appetite □excessive thirst □frequent nausea □vomiting
□liver problems □diarrhea □constipation □colitis
□gall bladder problems □weight problems □abdominal pain □bloating
□black/bloody stool □heartburn □irritable bowel syndrome

Genito-Urinary

□bladder trouble □painful/excessive urination □discolored urine
Males □prostate/sexual dysfunction
Females Are you pregnant? □yes □no □not sure
When was your last period?_____
Any problems with menstruation?_____
Did your last physical include:□pap smear □breast exam
Do you do a monthly self breast exam? □yes □no

Heart Conditions

□pacemaker □irregular heartbeat □ankle swelling □stroke
□short of breath □chest pain (angina) □varicose veins □lung disease
□blood pressure problems □arterio/atherosclerosis

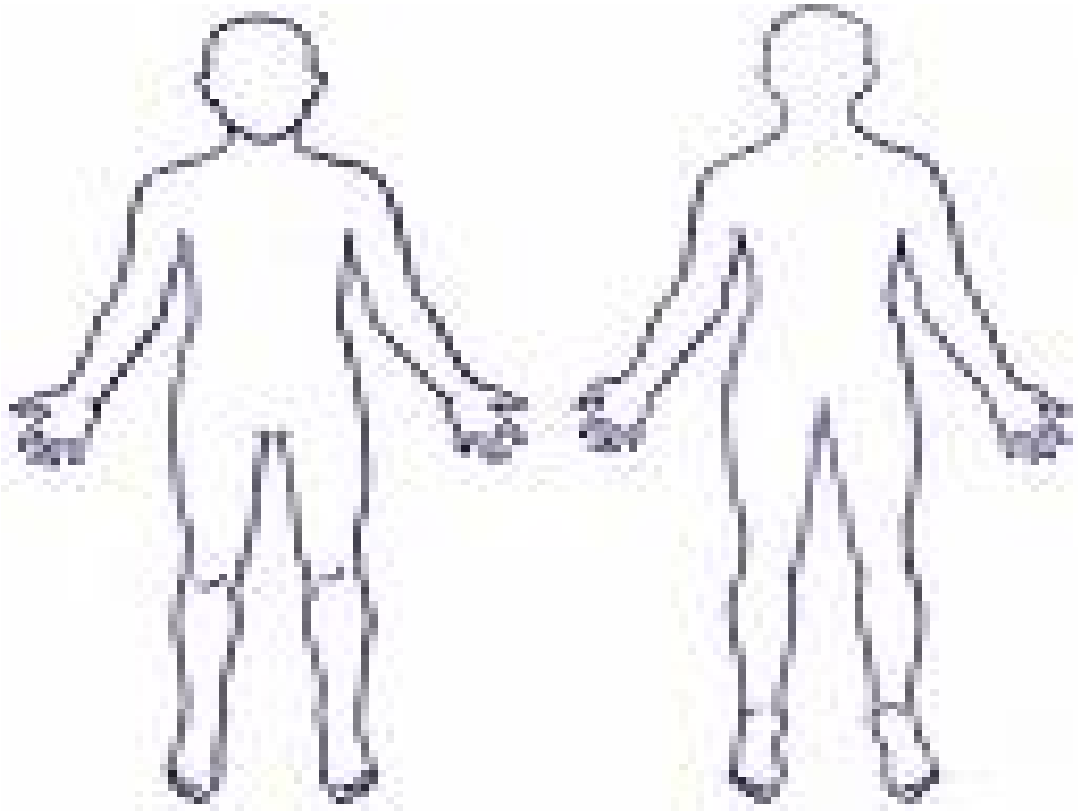
Lifestyle

□fatigue □loss of sleep □fever □headaches
□coffee □tea □pop □tobacco □alcohol

Other

□vision problems □dental problems □ear infections □hearing problems

Using the appropriate symbols, mark the areas of your body where you feel the described sensations. Include all affected areas. (**) Numbness (!!!) Pins and Needles (XX) Aching (ZZ) Burning (VV) Stabbing



FRONT BACK

Please mark on the line your **present** pain level:

NO PAIN 0----1----2----3----4----5----6----7----8----9----10 WORST PAIN
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