Active Health Chiropractic
& WELLNESS CENTRE

Patient Intake Form

Personal Information

Last Name: _____ First Name: _____

Address: _____

City: _____Postal Code: _____

Occupation: _____

Employer: _____

Age: _____ Birth Date (dd/mm/yyyy): _____

Sex: M / F Height: _____ Weight: _____

Alberta Health Care #: _____

Secondary Insurance: _____

Home Phone: ____-_____-_____

Cell Phone: ____-_____-_____

Work Phone: ____-_____-_____

Email: _____

How do you prefer to be contacted for appointment reminders (please check one):

[ ] Phone [ ] Text [ ] Email

Family Information

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Spouse's Name: _____

# of Children: ____ Children Names and Ages: _____

_____

In Case of Emergency Contact: _____ **Phone:** _____

Whom may we thank for referring you? _____

Is your complaint due to an accident? [ ] Yes [ ] No Date: ____/_____/_____

If yes, what type of accident? [ ] Automobile [ ] Work [ ] Other: _____

To whom have you reported the accident? [ ] Insurance [ ] WCB [ ] Employer [ ] Other:

Primary Reason for Seeking Chiropractic Care:

Have you had Chiropractic care before? [ ] Yes [ ] No

Any other treatments for this complaint? _____

Reason for appointment: _____ When did your complaint begin? _____

Have you ever had similar problems in the past? [ ] Yes [ ] No

Since it began, is it: [ ] Same [ ] Better [ ] Worse

Is this complaint interfering with: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other: _____

What activities aggravate/worsen your complaint? _____

What activities reduce/lessen your complaint? _____

Indicate your current intensity/severity by circling a number below:

(No complaint/pain) 0 -- 1 -- 2 -- 3 -- 4 -- 5 -- 6 -- 7 -- 8 -- 9 -- 10 (Worst pain imaginable)

List any previous surgeries, illnesses, injuries or broken bones/fractures: _____

_____

_____

List ALL medications that you are currently taking (prescriptions, over the counter, etc): _____

_____

List ALL vitamins or supplements that you are currently taking: _____

_____

Family Medical Doctor: _____

Using the symbols below, mark on the pictures where you feel pain:

N = Numbness/Tingling

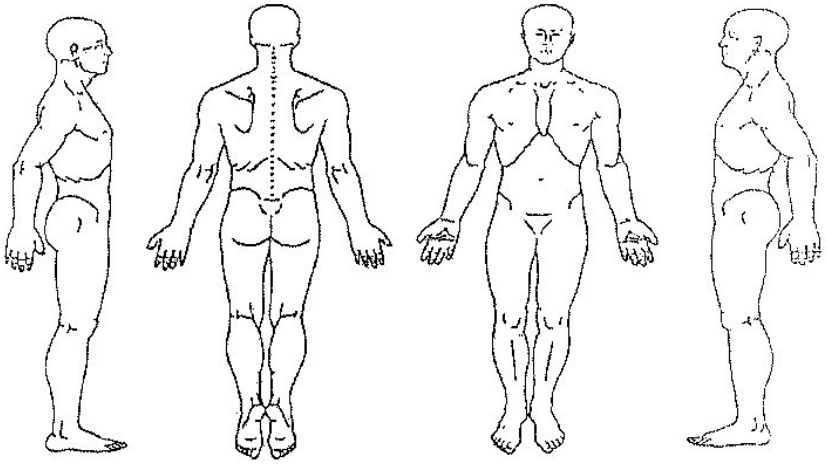
A = Aching

B = Burning

S = Sharp/Stabbing

P = Pins/Needles

O = Other _____



Please mark any of the following conditions/symptoms that you have NOW or have experienced in the last 6 months:

GENERAL SYMPTOMS
[ ] Headaches
[ ] Dizziness
[ ] Tension
[ ] Fainting
[ ] Irritability
[ ] Fever
[ ] Fatigue
[ ] Numbness
[ ] Loss of balance

MUSCLES/JOINTS
[ ] Neck pain
[ ] Upper back pain
[ ] Mid back pain
[ ] Low back pain
[ ] Sprains/Strains
[ ] Weak muscles
[ ] Jaw/TMJ problems

CARDIO-VASCULAR
[ ] High blood pressure
[ ] Heart attack
[ ] Stroke
[ ] Poor circulation
[ ] Heart palpitations
[ ] Chest pain
[ ] Swelling of ankles

EYE/EAR/NOSE/ THROAT
[ ] Vision problems
[ ] Ear ache
[ ] Ringing in ears
[ ] Deafness
[ ] Nasal congestion
[ ] Nose bleeds
[ ] Frequent colds
[ ] Loss of smell/taste

GASTRO-INTESTINAL
[ ] Diarrhea
[ ] Constipation
[ ] Upset stomach
[ ] Heartburn/Reflux
[ ] Abdominal pain
[ ] Ulcers
[ ] Weight loss / gain

RESPIRATORY
[ ] Asthma
[ ] Chronic cough
[ ] Difficulty breathing
[ ] Shortness of breath

GENITO-URINARY
[ ] Painful urination
[ ] Loss of bladder control

WOMEN ONLY
[ ] Irregular cycle
[ ] Menstrual cramps
[ ] Menopause
Pregnant? Y / N
Due date: _____

MEDICAL CONDITIONS
[ ] Alcoholism
[ ] Allergies
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Cancer
[ ] Depression
[ ] Diabetes
[ ] Edema
[ ] Epilepsy
[ ] Gout
[ ] Heart disease
[ ] Hernia
[ ] High cholesterol
[ ] HIV/Aids
[ ] Mental disorder
[ ] Multiple sclerosis
[ ] Osteoporosis
[ ] Pace maker
[ ] Thyroid disease

Do you have a Family History of:

[ ] Arthritis	[ ] Heart Disease
[ ] Cancer	[ ] Osteoporosis
[ ] Diabetes	[ ] Stroke

Habits:	**Alcohol**	**Coffee**	**Tobacco**	**Exercise**	**Sleep**	**Water**
None	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Light	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Moderate	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

_____ _____ _____

Signature | Date | Legal Guardian (if patient is a minor)