Summerside Chiropractic
Intake Form

Date __/__/____

New Patient Information

Name: Email*: *Optional Email (for Apt reminders)

Phone #: Alberta Health Care #

Address: Date of Birth: Sex: Male ☐ Female ☐

City/Postal Code: Gender: Male ☐ Female ☐ Other

Name of Partner: Status: Married ☐ Single ☐ Child ☐ # of Children:

Motor Vehicle Accident: Yes ☐ No ☐

Referred by: Worker's Compensation Board: Yes ☐ No ☐

Occupation: Insurance: Yes ☐ No ☐ If Yes, Insurer:

Physician: Previous Chiropractor:

Emergency Contact: Approx. Date of last Visit:

Emergency #: Reason for Previous Visit: Check Up ☐

Other:

We offer different types of care.

Check more than one box if applicable so that we may be guided by your wishes.

- ☐ Spinal/Health check up
- ☐ Pain Relief
- ☐ Corrective Care (prevents re-occurance of pain by addressing the underlying cause)
- ☐ Wellness Care (A proactive approach to health that maximizes your health potential by optimizing nerve function, diet and exercise.)

Adult & Child:

What is your concern(s): _____

How long have you/ your child had these symptoms: _____

Have you had this similar symptoms in the past? _____

What activities aggravate you/child's symptoms? _____

Are these symptoms getting progressively worse? Y__ N__ Constant__ Comes and Goes __

Are these symptoms Interfering with your Work/School__ Sleep__ Daily Routine__ Eating __ Other? _____

How long has it been since you really felt good? _____

Others professionals who have treated this condition? _____

Result with treatment? _____

In the past 5 years, have x-rays been taken? Y__ N__ If Yes, Where? _____

Adult & Child:

Are you currently on a program of: _____

a) vitamins__ b) minerals__ c) herbs__ d) diet__ e) exercise__ f) other _____

What is your estimation of your present general Health: Excellent __ Good__ Fair__ Poor__

Are you frequently Ill? Y__ N__

Do you often feel exhausted? Y__ N__

Do you have trouble sleeping? Y__ N__

Are you worried about receiving chiropractic care? Y__ N__

Adult & Child +12 Health History

Below are a list of diseases which may seem unrelated to the purpose of your appointment. These questions must be answered carefully as these problems can effect your overall course of chiropractic care.

Musculo-Skeletal Code
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ General Stiffness

Nervous System Code
- ☐ Numbness
- ☐ Headaches
- ☐ Dizziness
- ☐ Forgetfullness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Cold/Tingling Extrem.
- ☐ Recent Surgery
- ☐ Wear Pacemaker

Gastro-Intestinal Code
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Blader Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

C-V-D Code
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Ankle Swelling
- ☐ Stroke

Genito-Urinary Code
- ☐ Blader Trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discoloured Urine
- ☐ Gas/Bloating after meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

Male/Female Code
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other

EENT Code
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearig Difficulty
- ☐ Stuff Nose (Sinuses)

Check any of the following diseases you have had:
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Illness
- ☐ Eczema

Causes of Spinal / Nerve Problems

What are your Total Stresses? ***High-3 / Med-2 / Low-1***

A: Emotional Stresses
- ☐ Work /School
- ☐ Social
- ☐ Family

Total A:_ _ _

B: Chemical Stresses
- ☐ Environment
- ☐ Smoker - Amount?
- ☐ Second-hand smoke
- ☐ Poor Diet
- ☐ Caffeine
- ☐ Excessive sugar
- ☐ Artificial Sweeteners
- ☐ Prescription Drugs*
  Specify _____
- ☐ Over the Counter Drugs*
  Specify _____

Total B:_ _ _

C: Physical Stresses
- ☐ Birth Trauma
- ☐ Slips/falls
- ☐ Car Accidents
- ☐ Knocked unconscious
- ☐ Sports injuries
- ☐ Poor Posture
- ☐ Sitting on your wallet
- ☐ Sleeping positions (stomach)
- ☐ Extensive computer work
- ☐ Carrying heavy purse/bag/child
- ☐ Repetitive lifting/bending
- ☐ Continous hours sitting/standing
- ☐ Bone Fracture / Surgery

Total C:_ _ _

Total Stress: A+B+C
_____

- ☐ I have no discomfort, I am here for a check-up and Wellness care
- ☐ I do have discomfort in the following areas:

Mark Areas on this body where you feel the described sensations
Can be filled out in Clinic

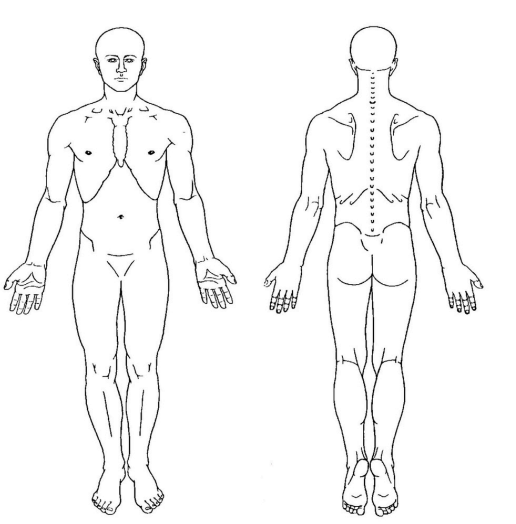
Numbness ● ● ●

Pins & Needles 000

Burning X X X

Aching A A A

Stabbing / / /



Pain Level

0 — 10