THE CHIROPRACTIC HEALTH CENTRE

4141 Albert Street, Regina SK S4S 3R6
Phone: (306) 359-3060
Website: chirohealthcentre.com

PATIENT INTAKE FORM

Name _____ Phone # _____ Email _____

Age _____ Alt Contact _____ Phone # _____

Who referred you to this office? _____

If you will be claiming your chiropractic treatment under any of the following, please check the appropriate box.

☐ SGI ☐ WCB Claim # _____ Adjuster _____

☐ DVA ☐ RCMP License # _____

REASON FOR CONSULTING THIS OFFICE

Describe your chief complaint. _____

How did this occur? _____

Have you sought any other treatment for this condition? If so, what? _____

SYMPTOM DESCRIPTION

Please check the type of discomfort you are feeling:

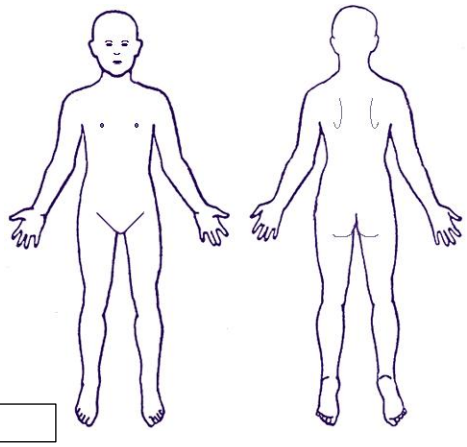
☐ achy ☐ burning ☐ numbness ☐ pins and needles ☐ sensitive to touch ☐ stabbing ☐ other

Please rate your pain on the Pain Rating Scale below, with 0 being no pain and 10 being excruciating pain.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please draw on the diagram where you feel the discomfort.

NOTE: please print this page and draw the area of discomfort in pen.



What seems to aggravate these symptoms? _____

What seems to relieve these symptoms? _____

Have you had any X-rays taken for this area of complaint? If yes, please indicate location and approximate date X-rays were taken. _____

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GENERAL HEALTH/LIFESTYLE INFORMATION

Name _____ **Height** _____ **Weight** _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many per week? _____

Do you have good sleep habits? ☐ Yes ☐ No

Do you have a good appetite? ☐ Yes ☐ No

Do you have a healthy diet? ☐ Yes ☐ No

Have you had any previous injuries? ☐ Yes ☐ No

Have you been hospitalized? ☐ Yes ☐ No
If yes, reason: _____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please list: _____

Are you involved in any recreational/exercise activities? ☐ Yes ☐ No
If yes, please list: _____

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list: _____

Are there any family health conditions or problems? ☐ Yes ☐ No
If yes, please list: _____

Have you been diagnosed with any of the following?

☐ Aneurysm ☐ Osteoporosis ☐ Diabetes ☐ Arthritis ☐ Cancer ☐ Stroke

GENERAL HEALTH – WOMEN ONLY

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional **F = Frequent** **C = Constant**

O	F	C		O	F	C		O	F	C		O	F	C	
☐	☐	☐	cramps	☐	☐	☐	heavy flow	☐	☐	☐	irregular cycle	☐	☐	☐	sore breasts
☐	☐	☐	discharge	☐	☐	☐	light flow	☐	☐	☐	painful cycle				

Menopausal ☐ Yes ☐ No Last menstruation date: _____

Pregnant ☐ Yes ☐ No Due date: _____

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GENERAL HEALTH – ALL PATIENTS

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O	F	C	
☐	☐	☐	allergy
☐	☐	☐	chills
☐	☐	☐	convulsions
☐	☐	☐	dizziness
☐	☐	☐	fainting
☐	☐	☐	fevers
☐	☐	☐	headaches
☐	☐	☐	loss of sleep
☐	☐	☐	nervousness
☐	☐	☐	depression
☐	☐	☐	neuralgia
☐	☐	☐	numbness
☐	☐	☐	sweats
☐	☐	☐	loss of weight
☐	☐	☐	tremors

MUSCLE & JOINT

☐	☐	☐	arthritis
☐	☐	☐	bursitis
☐	☐	☐	foot trouble
☐	☐	☐	hernia
☐	☐	☐	low back pain
☐	☐	☐	neck pain
☐	☐	☐	neck stiffness
☐	☐	☐	pain between shoulders

RESPIRATORY

☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	spitting blood
☐	☐	☐	throat phlegm
☐	☐	☐	wheezing

EYES, EARS, NOSE, THROAT

☐	☐	☐	asthma
☐	☐	☐	colds
☐	☐	☐	crossed eyes
☐	☐	☐	deafness
☐	☐	☐	dental decay
☐	☐	☐	ear aches
☐	☐	☐	ear discharges
☐	☐	☐	ear noises
☐	☐	☐	sinus infections
☐	☐	☐	enlarged glands
☐	☐	☐	enlarged thyroid
☐	☐	☐	sore throats
☐	☐	☐	tonsillitis
☐	☐	☐	eye pain
☐	☐	☐	failing vision
☐	☐	☐	far sighted
☐	☐	☐	gum trouble
☐	☐	☐	hay fever
☐	☐	☐	hoarseness
☐	☐	☐	nasal obstruction
☐	☐	☐	near sighted
☐	☐	☐	nosebleeds

CARDIO-VASCULAR

☐	☐	☐	hardening of arteries
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	pain over heart
☐	☐	☐	poor circulation
☐	☐	☐	rapid heartbeat
☐	☐	☐	slow heart beat
☐	☐	☐	swelling of ankles

GASTRO INTESTINAL

☐	☐	☐	burping or gas
☐	☐	☐	colitis
☐	☐	☐	colon trouble
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	difficult digestion
☐	☐	☐	distension of abdomen
☐	☐	☐	excessive hunger
☐	☐	☐	gall bladder trouble
☐	☐	☐	hemorrhoids
☐	☐	☐	liver trouble
☐	☐	☐	stomach pain
☐	☐	☐	intestinal worms
☐	☐	☐	jaundice
☐	☐	☐	poor appetite
☐	☐	☐	nausea
☐	☐	☐	vomiting
☐	☐	☐	vomit blood

SKIN

☐	☐	☐	boils
☐	☐	☐	bruise easily
☐	☐	☐	dryness
☐	☐	☐	hives or allergy
☐	☐	☐	itching
☐	☐	☐	skin rash
☐	☐	☐	varicose veins

GENITO-URINARY

☐	☐	☐	bed wetting
☐	☐	☐	blood in urine
☐	☐	☐	frequent urination
☐	☐	☐	loss of urine control
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble
☐	☐	☐	pus in urine
☐	☐	☐	smell of urine

PAIN OR NUMBNESS IN:

☐	☐	☐	arms
☐	☐	☐	shoulders
☐	☐	☐	hands
☐	☐	☐	hips
☐	☐	☐	legs
☐	☐	☐	knees
☐	☐	☐	ankles
☐	☐	☐	feet
☐	☐	☐	painful tail bone
☐	☐	☐	sciatica
☐	☐	☐	swollen joints