ADELAIDE CLINIC
CHIROPRACTIC + MASSAGE THERAPY + ACUPUNCTURE

NEW CHIROPRACTIC PATIENT INTAKE

To allow us to provide you with the best possible care, please print and complete this form as thoroughly as possible and bring it with you to your first appointment. All information is strictly confidential.

Patient Information

Date: ____________________ Gender: ____________ E-mail: ________________________

Full Name: ______________________________ Preferred Name: ____________________

Street Address: ____________________ Postal Code: __________ City: __________ Prov: ______

Home Phone: ______________ Cellphone: ______________ Work: ______________

Age: _____ Birthdate: (D) ____ / (M) ____ / (Y) _____ Ontario Health Care Number: ______________

Marital Status: ____________ Occupation: ____________ Employer: ____________________

Emergency Contact: ______________ Relationship: __________ Phone No: ______________

Medical Information

Family Medical Doctor's Name: ____________________ Clinic: ____________________

Date of last MD visit: ______________ Reason: ______________________________

Date of last physical examination: ______________

What therapy have you previously received? Chiropractic Massage Acupuncture Physiotherapy

**Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at AC to contact your medical doctor?* Yes No

Extended Health Benefits & Other Insurance

Do you have a private insurance plan? No Yes (Self) Yes (Spouse) Yes (Parent)

Name of primary policy holder (Spouse/Parent): ______________________

Which company? Blue Cross SunLife Great West Life Green Shield Standard Life SSQ Financial Chamber of Commerce Desjardins Cowan Industrial Alliance Johnson Manulife
Other: ____________

Policy No: ______________ Member ID: ______________ Group No: *(*ABC Only)* __________

Is this a Workman's Compensation Case (WSIB)? No Yes Date of the Accident: ______________

Is this a Motor Vehicle Accident Case (MVA)? No Yes Date of the Accident: ______________

How Did You Find Us?

Referred by Friend/Family Referred by Medical Doctor Internet/Website Street Sign

Referred by Trainer Walk In Health Care Event Other: ______________

*Whom may we thank for this referral? ______________________

Current Health Condition &/or Injury

Primary Complaint: ______________________________ When did this begin? ____________________

Have you had this before? No Yes; When: ____________ Is it getting: Worse Better Not Changing

Is the condition: Work--Related Auto--Related Sports--Related Fall Other: ____________________

What is the character of the pain? Dull & Achy Stiff & Tight Sharp Pins & Needles Numb Burning

Please rate your pain: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

When do you feel the pain? Constantly Intermittently Only at Night Only in the Morning

Does the pain radiate down your legs or arms? No Yes; Describe: ______________________________

What aggravates your pain? Sitting Standing Bending Lifting Exercise Weather Changes Rest

What relieves your pain? Rest Movement Heat Ice Massage Medication: ________________

Have you seen anyone else for this condition? No Yes: ______________________________

Have you had any imaging for this condition: X--Ray CT MRI Ultrasound Date: ______________

Does this problem interfere with: Work Family & Social Life Sports & Hobbies Sleep

What is your commitment to correcting this problem: 0 1 2 3 4 5 6 7 8 9 10

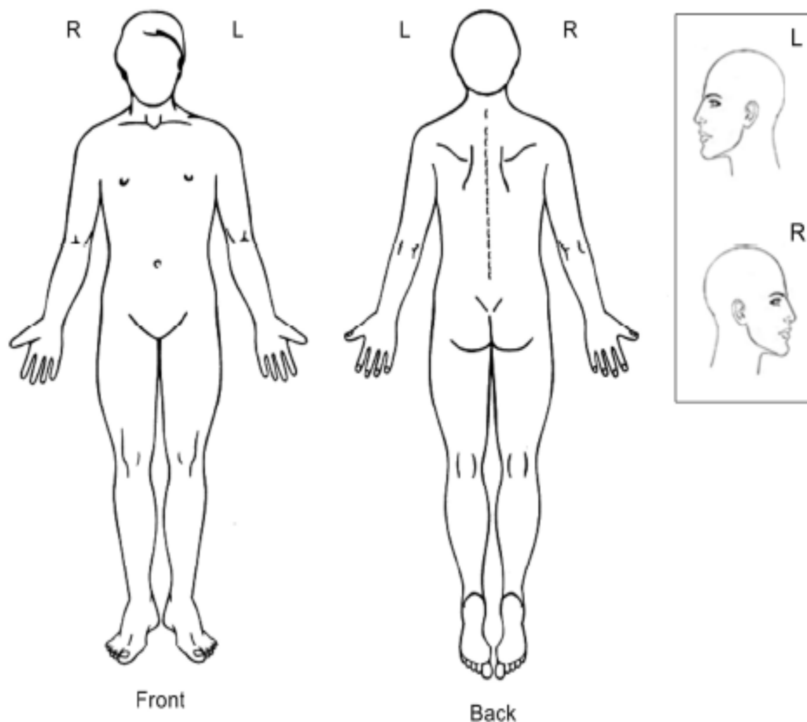
Do you have any secondary complaints? ____

____

Symptom Diagram

Please use the symbols below to mark all of the areas on the diagram that BEST represent the pain and sensations that you are CURRENTLY experiencing

Numbness	====	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Lifestyle

Are you currently a smoker? No Yes; Amount: _______ Did you smoke previously? No Yes; When: ______

Do you consume alcohol? No Yes; Amount/Frequency: ____________ Coffee? No Yes; Amount: __________

Do you have a healthy & balanced diet? No Don't Know Yes, I think so Yes, definitely

Do you exercise regularly? No Yes; Type & Frequency: ____

What are your stress levels? Extreme High Moderate Low Very Minimal

Health History

Have You Ever Had…

Fracture: No Yes; Where/When: ______________ Major surgery: No Yes; Where/When: ________________

Car accident: No Yes; When: __________ Been hospitalized: No Yes; When/Why: ______________________

A concussion: No Yes; When & How: ____

Been diagnosed with: Cancer HIV/AIDS Hepatitis A/B/C Other: ________ When: _______________

High blood pressure: No Yes; When: _______________ High cholesterol: No Yes; When: _________________

Are you pregnant? No Yes; Due Date: ___________ No. of Past Pregnancies: ______ No. of Children: _______

Do you have any allergies: No Yes; List: ____

Please list any medications/supplements that you are currently taking: ________________________________

____

Family History

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
*Mother's Side:	☐	☐	☐	☐	☐	______________
*Father'sSide:	☐	☐	☐	☐	☐	______________

Health Status Survey

Please check the box for any conditions or symptoms that you have had in the ***past six months***

General
Fainting
Headaches
Fever
Excessive Sweating
Loss of Weight
Night Pain
Loss of Sleep
Anxiety/Nervous

Neurological
Dizziness
Blurred Vision
Paralysis
Numbness/Tingling
Clumsiness
Nausea
Convulsions
Loss of Balance

Genitourinary
Trouble Urinating
Blood in Urine/Stool
Kidney Infection
Prostate Trouble
Painful Menstruation
Irregular/Absent Cycle
Painful Breasts
Menopause

Respiratory
Asthma
Chronic Cough
Difficulty Breathing
Sinus Infections
S pitting up Blood
Spitting up Phlegm
Sore Throat
Frequent Colds

Muscle & Joint
Low Back Pain
Mid Back Pain
Neck Pain
Shoulder/Arm Pain
Elbow Pain
Knee/Leg Pain
Hip/Groin Pain
Wrist/Hand Pain
Ankle/Foot Pain
TMJ/Jaw Pain
Fibromyalgia
Arthritis
Disc Herniation
Sciatica
Gout

Cardiovascular
Chest Pain
Previous Heart Attack
Previous Stroke
Angina
Ankle Swelling
Poor Circulation
Irregular Heartbeat
☐Varicose Veins

Gastrointestinal
Poor/Excessive Appetite
Belching/Gas
Vomiting
IBS
Constipation
Diarrhea
Crohn's
☐Heartburn

Eyes/Ears/Nose/Throat
Earaches/Infection
Ringing in Ears
Hearing Difficulty
Eye Pain
Worsening Vision