KLEINBURG
INTEGRATIVE HEALTH

New Patient Intake Form – Chiropractic Medicine

Patient Information

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. _____
First Name Surname

Address: _____
Street City/Town Postal code

Age: _____ Date of Birth: _____ Marital Status: _____
YYYY / MM / DD

Phone #: Home ( ) _____ Work: ( ) _____ Cell: ( ) _____

Can we leave a message? If yes, please specify at which location ☐ Home ☐ Work ☐ Cell

Occupation: _____ Employer's Name: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Physicians Name: _____ Phone #: ( ) _____

Address: _____
Street City/Town Postal code

Extended Health Care Carrier (if Applicable): _____

How did you hear about this office? _____

Were you referred to this office? ☐ Yes ☐ No If Yes, by whom? _____

Health Information

Have you had previous: ☐ Chiropractic Care ☐ Physiotherapy ☐ Acupuncture ☐ Massage Therapy

If yes, please specify the reason for care: _____

Please specify the reason for today's visit: _____

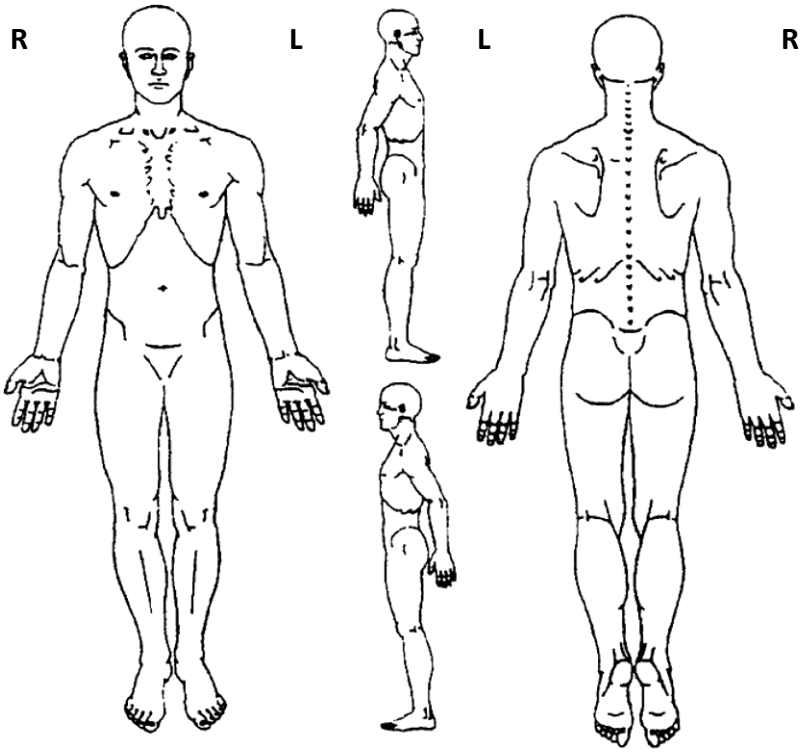
Have you had this pain before? ☐ Yes ☐ No If, yes when: _____

How are the symptoms changing? ☐ Gotten worse ☐ Stayed the same ☐ Gotten better

Is your Injury a result of: ☐ Motor Vehicle Accident ☐ Work Related ☐ Sport Related

If Other Please Specify: _____

Instructions: Please mark the area of injury or discomfort on the adjacent diagram, using the appropriate symbols:	
Numbness	– – – – – – – – – – – –
Pins & Needles	○○○○○○○○○○
Aching	+ + + + + + + + + + + +
Burning	XXXXXXXXXXXXXXXXX
Stabbing	//////////////////////



On a scale of 0 to 10, please circle the average intensity of your symptoms:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst possible pain**

Review of Systems – Mark (**X**) in the box below for current and (**√**) for past conditions or symptoms

Musculoskeletal System
- ☐ Neck problems
- ☐ Upper back problems
- ☐ Shoulder problems
- ☐ Elbow/wrist problems
- ☐ Low back problems
- ☐ Knee problems
- ☐ Ankle/knee problems
- ☐ Arthritis

Nervous System
- ☐ Numbness or tingling
- ☐ Loss of feeling
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Confusion
- ☐ Depression
- ☐ Forgetfulness
- ☐ Seizures/Epilepsy

Genito-Urinary System
- ☐ Painful urination
- ☐ Excessive urine
- ☐ Scanty urine
- ☐ Discolored urine
- ☐ Incontinence/retention

Cardio-vascular-respiratory
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm/blood
- ☐ Lung problems
- ☐ Varicose veins/phlebitis
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Pacemaker or similar device

Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Abdominal pain
- ☐ Excessive thirst
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Incontinence
- ☐ Bloody/black stool
- ☐ Liver/gallbladder trouble
- ☐ Weight trouble

Ear, Eyes, Nose and Throat
- ☐ Eye problems
- ☐ Vision problems
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Allergies
- ☐ Hoarseness

Female
- ☐ Premenstrual syndrome
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Pregnancy
- ☐ Breast pain and/or lumps

Infections
- ☐ Fever
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Medications

Are you currently taking any medications (prescription or over the counter)? If yes, please note:

1- Medication _____ Dosage _____
2- Medication _____ Dosage _____
3- Medication _____ Dosage _____
4- Medication _____ Dosage _____
5- Medication _____ Dosage _____

Family History

Please check if any one of your family members have or have had any of the following, and if so how are you related?

☐ Cancer _____ Mother _____ Father _____ Sibling _____ Other (specify) _____
☐ Heart Disease _____ Mother _____ Father _____ Sibling _____ Other (specify) _____
☐ Stroke _____ Mother _____ Father _____ Sibling _____ Other (specify) _____
☐ Diabetes _____ Mother _____ Father _____ Sibling _____ Other (specify) _____
☐ High Cholesterol _____ Mother _____ Father _____ Sibling _____ Other (specify) _____
☐ Hypertension _____ Mother _____ Father _____ Sibling _____ Other (specify)
☐ Other, Please specify _____

Social History

Do you smoke? ☐Yes ☐No If yes, how many packs/day? _____ For how long? _____

Do you consume alcohol? ☐Yes ☐No If yes, how many drinks/week? _____

Do you exercise? ☐Yes ☐No If yes, how many times/week? _____

Terms and Policies

We require **24 hours notice**, if a patient/client is unable to keep a scheduled office appointment. This allows the clinic to accommodate other patients/clients. All patients/clients who cancel appointments with fewer than 24 hours notice will be subject to the full service fee.

I have read and understand this policy.

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Chiromedics Health Centre of any changes to my status.

Print Name _____

Sign Name _____

Today's Date _____

Consent to Chiropractic Treatment:

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be-caused, by spinal adjustments or chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____, day of_____, 20_____,

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**

(please print) **(please print)**