Chiropractic Intake Form

Pickering Chiropractic Health Centre
#1-1154 Kingston Road, Pickering, Ontario L1V 1B4
T: 905-420-1443 F: 905-420-9210
Website: www.pickchiro.ca | E-mail: pickchiro@bellnet.ca
Dr. J. Boylan D.C. | Dr. J. Collins D.C. | Dr. M. Frazier D.C.

Patient Information

Full Name: .... Date: ....

Birth Date: .... Age: .... Gender: ☐ Male ☐Female ☐ Gender Neutral

Address: .... City: ....

Province: .... Postal Code: .... Marital Status: ☐ Single ☐ Married # of Children: ....

Cell #: .... Home #: .... Work #: ....

Occupation: .... E-mail: ....

Emergency Contact: .... Relationship: .... Phone #: ....

Medical Information

Medical Doctor's Name: .... Clinic: ....

Date of last MD visit: .... Reason: ....

What therapies 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 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)

Card Holder name.............................. Policy #.............. ..... Member ID#..............................

Card Member DOB.............................. Signature for authorization......................................

Is this a WSIB case? ☐ Yes ☐ No Date of Accident? ....

Is this a Motor Vehicle Accident Case (MVA)? ☐ Yes ☐ No Date of Accident? ....

How Did You Hear About Us?

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Walk In ☐ Other: ....

*Whom may we thank for this referral? ....

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Current Health Condition &/ Injury

Primary Complaint: ....

When did this begin? ....

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

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

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 the arms or legs? ☐ Yes ☐ No Describe: ....

Have you seen anyone else for this condition? ☐ Yes ☐ No Who: ....

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

What aggravates your pain? ☐ Sitting ☐ Standing ☐ Walking ☐ Exercise ☐ Bending ☐ Lifting ☐ Rest

☐ Other: ....

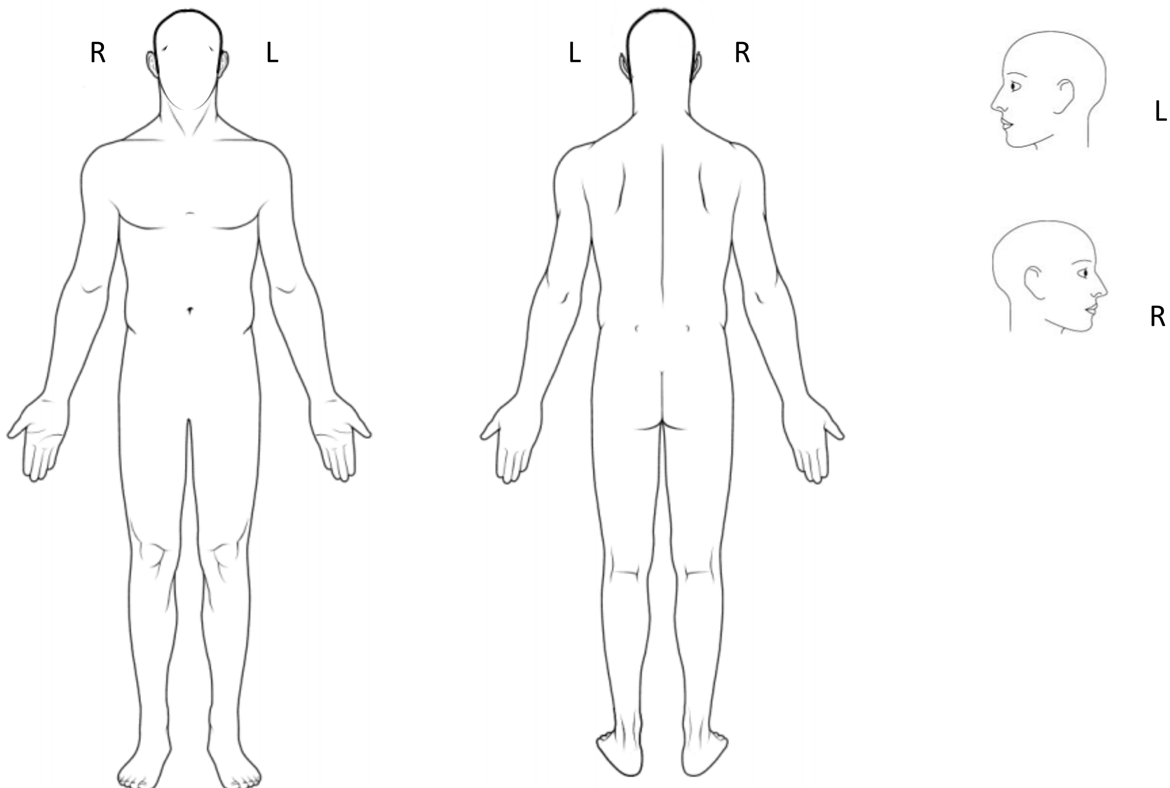
What relieves your pain? ☐ Rest ☐ Movement ☐ Heat ☐ Ice ☐ Massage ☐ Medication: ....

☐ Other: ....

Do you have any secondary complaints? ....

Symptoms Diagram

Please use the symbols below to mark all the areas on the diagram that BEST represent the pain and sensation that you are CURRENTLY experiencing: Numbness ☐ Pins/Needles △ Burning O Sharp ✓ Dull/Achy ✕ Stiff/Tight =



Health History

Have you ever had:

Fracture: ☐ Yes ☐ No Where/When?: . . . . Major Surgery: ☐ Yes ☐ No Where/When?: . . . .

Car Accident: ☐ Yes ☐ No When?: . . . . Concussion: ☐ Yes ☐ No When?: . . . .

Been Hospitalized: ☐ Yes ☐ No When? . . . .

Been diagnosed with: ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Arthritis

☐ Osteoporosis ☐ Other: . . . . When: . . . .

Do you have allergies? ☐ Yes ☐ No List: . . . .

Please list any medication/supplements that you are currently taking: . . . .

. . . .

For Women Patients Only

Are you pregnant? ☐ Yes ☐ No Due date? . . . . # of past pregnancies: . . . .

Your last menstrual period started on: . . . . Are you using any contraception? ☐ Yes ☐ No

Do you experience severe cramping with you menstrual period? ☐ Yes ☐ No Do you suffer from PMS? ☐ Yes ☐ No

Family History

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mother's side:	☐	☐	☐	☐	☐	☐ . . . .
Father's side:	☐	☐	☐	☐	☐	☐ . . . .

Lifestyle

Are you currently a smoker: ☐ Yes ☐ No Amount? . . . . Did you previously smoke: ☐ Yes ☐ No When? . . . .

Do you exercise? ☐ Yes ☐ No Type/frequency: . . . .

Do you have a healthy and balanced diet: ☐ No ☐ Yes, I think so ☐ Yes, definitely ☐ Don't know

What are your stress levels? ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐ Very minimal

Health History

Please check the box of any condition or symptoms that you have currently with a ☑

General:

- ☐ Fever
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Unexplained weight loss
- ☐ Night Sweats
- ☐ Excessive Fatigue
- ☐ Anxiety
- ☐ Headaches

Neurological:

- ☐ Difficulty speaking
- ☐ Difficulty swallowing
- ☐ Changes to vision
- ☐ Double Vision
- ☐ Fainting
- ☐ Numbness
- ☐ Nausea
- ☐ Loss of sensation in the groin region
- ☐ Difficulty urinating
- ☐ Muscle Weakness

Do NOT sign this form until you meet with the Chiropractor

Patient Informed Consent to Chiropractic Examination

I acknowledge that I have discussed, or had the opportunity to discuss, with my chiropractor the purpose of the examination, potential risks, benefits, and side effects. I consent to the Chiropractic examination offered or recommended by my chiropractor. I intend this consent to apply to all present and future examinations.

_______________________________________ _______________________________________

Patient Signature | Patient Name (Please Print)

Patient Informed Consent to Chiropractic Treatment

Doctors of Chiropractic are required to advise patients that there are or may be some remote risks associated with such treatment. In particular, you should note: while rare some patients may experience a short term aggravation of symptoms, rib fracture, muscle and ligament strains or sprains, strokes and disc injuries.

I acknowledge that I have discussed, or had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments) as well as the contents of this consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent apply to all my present and future chiropractic care.

I understand that it is fully my responsibility to pay Pickering Chiropractic for my care at the time of treatment and to confirm with my insurance provider (if applicable) as to coverage for chiropractic care, acupuncture and orthotics. (Appropriate receipts will be provided for me to submit, however, Pickering Chiropractic is not responsible if I am denied coverage).

Date: ___________________________, 20______

Patient Signature | Chiropractor Signature

Patient Name (Please Print) | Chiropractor Name (Please Print)

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