PATIENT INTAKE

PATIENT INFORMATION

First Name	Last Name	Middle Name	
Date of Birth	**Gender**	**Title**	
Address	**City**	**Province**	**Postal Code**
Home Phone	**Cell Phone**	**Email**	

Contact Preference

Phone ☐ Email ☐

Emergency Contact

Emergency Contact Name	Emergency Contact Number	Relationship

Insurance

Health Care Benefits ☐ Yes ☐ No

Insurance Company	Policy/Contract Number	Group/Member Number
Profession	**Referral Method**	

WSIB/MVA

Car Accident☐ Workplace Injury☐ Personal Injury☐

Family Doctor/ Physician

Drs Name	Address	Phone Number

Current Health

Primary Complaint	Date of Injury	Pain Scale 0 1 2 3 4 5 6 7 8 9 10 0=No Pain/10=Worst Possible Pain

Have you visited a hospital for this issue? Yes ☐ No ☐	**Are you currently receiving treatment from another healthcare provider? If yes, please specify (Name, Type of care/treatment)**	Current Medications

What Makes it Worse?	What makes it better?	Describe your pain

When does it occur?	Where does the pain radiate to?	What's the progress of your condition?

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Previous Health

Provide a date and description of any surgeries, hospitalizations or car accidents

Have you had any treatment experience in one of the following?

- ○ **Chiropractic**
- ○ **Physiotherapy**
- ○ **Massage Therapy**
- ○ **Naturopathy**
- ○ **Acupuncture**
- ○ **Chiropody**

Other(Specify)

Do you have any metal implants or medical device(s)?

Yes ☐ **No** ☐

Have you had any exposure to medical equipment for any of your past conditions?

- ○ **MRI**
- ○ **X-Rays**
- ○ **CT-Scan**
- ○ **Ultrasound**

Other(Specify)

Please check any of the following that you experience

Cardiovascular

- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Stroke
- ○ Heart Attack
- ○ Heart Disease
- ○ Chronic Congestive Heart Failure
- ○ Blood Clots
- ○ Pacemaker
- ○ Bleeding Problems/Disorders
- ○ Phlebitis
- ○ Varicose Veins
- ○ Vascular Disease or Aneurysm

Respiratory

- ○ Asthma
- ○ Emphysema
- ○ Pneumonia
- ○ Bronchitis
- ○ Chronic Cough
- ○ Shortness of Breath
- ○ Other

Head & Neck

- ○ Vision Problems/Loss
- ○ Ear Problems/Hearing Loss
- ○ Headaches
- ○ Head Injury
- ○ Concussion
- ○ Dizziness/Fainting

Do you have any allergies?

Other conditions

- ○ Drugs
- ○ Diabetes
- ○ Sleeping Disorder
- ○ Loss of Sensation
- ○ Collagen Disease
- ○ Osteoporosis/Osteopenia
- ○ Convulsions, Seizures, Epilepsy
- ○ Arthritis
- ○ Skin Conditions
- ○ Cancer or Tumors

Do you have any infections?

- ○ Hepatitis
- ○ TB
- ○ HIV/AIDS
- ○ Other

Other Medical Conditions (Mental)

- ○ Depression
- ○ Panic
- ○ Stressed
- ○ Sleep Disorders

Family Health History

Lifestyle/Health Habits

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you exercise often? ☐ Yes ☐ No

Women's Health Habits

Are you pregnant? ☐ Yes ☐ No

Gynecological ☐ Yes ☐ No

Please provide any other details about your health ☐ Yes ☐ No