STONEBRIDGE CHIROPRACTIC

CHIROPRACTIC INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): _____ Middle Initial: _____ Sex: _____

Date of Birth: _____ Sask Health Card #: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Email: _____

Cell #: _____ Work #: _____

Occupation: _____ Employer:_____

Emergency Contact (Name & Phone Number): _____

Physician/Chiropractor's Name: _____

Who referred you to our clinic: _____

How do you prefer appointment reminders be sent to you? (Circle one): Email / Text message / Not at all

Can your Chiropractor send you prescribed exercises? (Circle one): Yes / No

Self-Check-In – Choose an easy to remember four-digit pin number of your choosing _____. We will put this number in your file for future use of our self-check- in services (iPad to the right of the front desk). This is handy when reception is not able to attend to you right away.

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients, Chiropractors and other providers, I understand that I must give **3 hours' notice** if I cannot make it to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, FHB, WCB and other insurances do not cover the cost of a missed appointment. Please help us serve you better by keeping scheduled appointments. _____ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood and agree to the above financial policies. _____ (Initial)**

Patient Signature: _____ **Date:** _____

CHIEF COMPLAINT:

Are your present symptoms or conditions related to/caused by (circle)?

Car Accident Work Injury Sudden Trauma Repetitive Trauma Unknown/Gradual

What is your chief complaint or reason for your appointment?

Please describe: _____

_____

How you would describe the pain (circle):

Sharp/Stabbing Dull/Ache Pins & Needles Numbness Burning

Please circle your level of pain below: (1 = minimal pain; 10 = worst pain imaginable)

Pain Currently

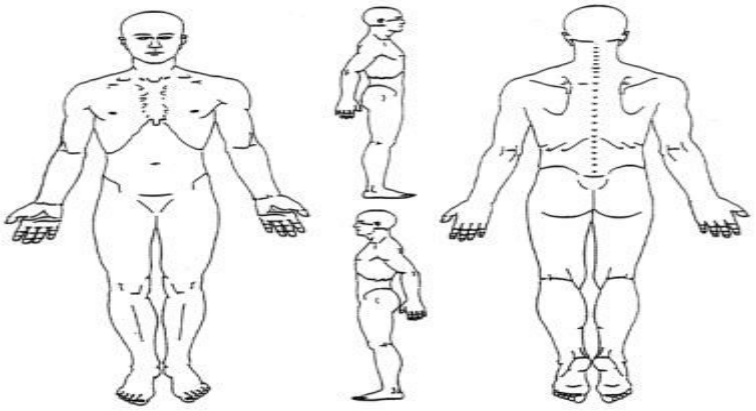
0 1 2 3 4 5 6 7 8 9 10

Pain Typically

0 1 2 3 4 5 6 7 8 9 10

Pain at its Worst

0 1 2 3 4 5 6 7 8 9 10



Is the pain constant or on/off? _____ Does the pain radiate? Yes / No Where: _____

Lately, has the pain been (circle)? getting better getting worse staying the same

Are the pain/symptoms worse in the (circle): morning night/at rest with activity

When did your condition first begin? _____

Have you had anything like this before? Yes / No When: _____

How often does the problem re-occur? _____

What makes it feel better?_____

What makes it feel worse? _____

Please list any activities you are unable to perform due to the pain, or for fear of making the pain worse?

_____

If you have seen another professional for the problem or done any self-care, describe the type of treatment AND results: _____

What else would you like the Doctor to know about you and/or your condition? _____

_____

MEDICAL INFORMATION: **PLEASE PRINT CLEARLY**

Height: _____ Weight: _____ Medical Doctor: _____

Last physical exam? _____ Results: _____

Have you had previous chiropractic care: Yes / No Dr's Name: _____ When: _____

What do you hope to do better or enjoy more when you regain your health? _____

Are you, or might you be pregnant? Yes / No # of pregnancies: _____ # of children: _____

Have you had blood pressure/ blood clotting issues? Yes / No

Please list and describe all significant previous injuries, surgeries, illnesses and hospitalizations you may have had: (sprains, fractures, accidents, etc.): _____
_____
_____
_____

Please describe your typical day: _____

Hours sitting: _____ Hours driving: _____ Hours standing: _____ Lifting: _____

How many days a week do you exercise? _____ Type of exercise: _____

How would you rate your stress level? No Stress 0 1 2 3 4 5 6 7 8 9 10 High Stress

How many servings of each per day? Meats _____ Fruit/ Veg _____ Grain/Pasta _____ Dairy: _____

Are you currently a smoker? Yes / No If No, did you smoke previously? Yes / No Yr. quit: _____

Please list any allergies: _____
_____

Please list any medications or supplements you take: _____
_____
_____

Please list any diseases, disorders, or major illnesses of biological family members. If deceased, from what? (ie: Cancer, diabetes, high blood pressure, stroke, etc.): _____
_____
_____
_____
_____
_____
_____
_____

PLEASE CHECK ALL THAT APPLY:

GENERAL SYMPTOMS:
- ☐ Blackouts
- ☐ Convulsions
- ☐ Excess sweating
- ☐ Fever
- ☐ Generalized pain
- ☐ Headache
- ☐ Loss of consciousness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Night pain
- ☐ Night Sweats

CARDIOVASCULAR:
- ☐ Angina
- ☐ Bleeding disorder
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ Heart disease
- ☐ Blood disease
- ☐ High blood pressure
- ☐ Poor circulation
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN:
- ☐ Boils
- ☐ Bruise easy
- ☐ Dryness
- ☐ Hives (allergies)
- ☐ Rashes/itching

RESPIRATORY:
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm

MUSCLES AND JOINTS:
- ☐ Ankle/foot pain
- ☐ Arm/forearm pain
- ☐ Arthritis
- ☐ Elbow pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Loss of strength
- ☐ Low back ache
- ☐ Mid back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Sore/stiff neck
- ☐ Wrist/hand pain

GASTROINTESTINAL:
- ☐ Belching/gas/indigestion
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Excess hunger
- ☐ Poor appetite
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Pain over stomach
- ☐ Ulcer
- ☐ Vomiting

GENITOURINARY:
- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Trouble urinating

GU FOR WOMEN:
- ☐ Cramping/backache
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Lump in breasts
- ☐ Painful menstruation
- ☐ Swollen breasts
- ☐ Vaginal discharge

EYES/EARS/NOSE/THROAT:
- ☐ Earache
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Failing vision
- ☐ Frequent colds
- ☐ Ring/buzz in ears
- ☐ Sinus infections

NEUROLOGIC:
- ☐ Blurred vision
- ☐ Clumsiness
- ☐ Dizziness
- ☐ Double vision
- ☐ Fainting
- ☐ Nausea
- ☐ Numbness or tingling
- ☐ Problems speaking
- ☐ Problems swallowing

Patient Signature: _____ Date: _____