Adult Intake Form

Today's Date: ______________________ Your Age: _______ Date of Birth: ______________

Name: ____________________________ Referred By: ______________________________

Address: ____ Postal Code: ________________

City/Province: ______________________ Occupation: _______________________________

Home Phone: ______________________ Employer: _________________________________

Office Phone: ______________________ Cell Phone: _______________________________

Email: ____________________________ Personal Health Number: ____________________

Marital Status: M S D W SEP CL Spouse Name: _____________________

# of Children & Ages: _____________ Pregnant? Due Date: _____________________

Emergency Contact Name: _____________ #: ______________ Relationship: ____________

History of Complaint

Please identify condition(s) that brought you here, and on a scale of 1 to 10 (10 being worst) rate your pain:

____

____

____

____

When is the problem at its worst? AM PM MID-DAY LATE PM How long does it last? _______

Is your problem the result of any type of accident? ICBC Workplace

How did the injury happen? ____

____

Do you currently wear OrthoticsÑ Shoe InsertsÑ I am a Smoker Non-Smoker

Have you seen another provider for this condition? Y N If yes, how long ago? ____________

State the types of treatment (Chiro/Physio/M.D./Specialist): _______________________________

Who provided it? __________________ What were the results? Favourable Unfavourable

Relevant History

When was your last visit to a chiropractor? _____________ Chiropractor's Name: _______________

What surgeries have you had? ____

Any relevant injuries or illnesses? ____

List any drugs or supplements you are taking: ______________________________________

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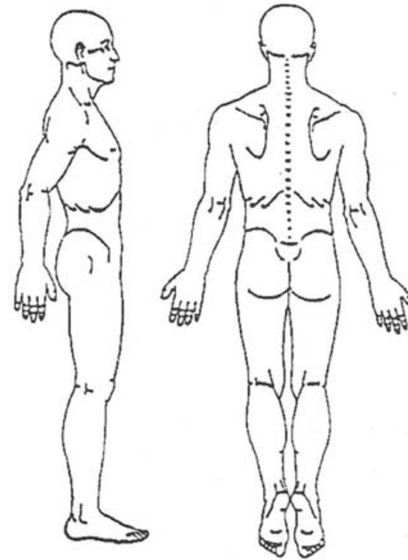

Symptom Diagram

Please mark areas on the diagram with the following bolded letters to describe your symptoms.

Radiating	**B**urning	**A**ching
Numbness	**S**harp/Stabbing	**T**ingling

Hereditary Diseases

Has anyone in your immediate family had any of the following conditions?

Heart Disease	Stroke	Diabetes	Alzheimer’s
Cancer	Heart Attack	Mental Illness	Muscular Dystrophy
Multiple Sclerosis	Spine Problems	High Blood Pressure	Arthritis

Symptoms – Please check any that apply:

Neck Pain
Numb / Tingling pain (upper)
Numb / Tingling pain (lower)
Upper back pain
Mid back pain
Lower back pain
Shoulder pain
Headache
Hip pain / Pelvic pain
Difficulty standing, walking or sitting
Difficulty with daily activities
Difficulty exercising
Difficulty bending or household duties
Fractured bones
Motor Vehicle Collisions
Accidents / Falls
Back curvature / Scoliosis
Arthritis
Swollen / Painful joints
Pain with coughing / sneezing
Foot trouble
Chest pain
Trouble sleeping

High blood pressure
Low blood pressure
Anemia
Asthma
Lung problems
Difficulty breathing
Heart problems
Stroke
Varicose veins
Impotence / Sexual dysfunction
Depression / Mood disorders
PMS
Menstrual problems
Menopausal problems
AIDS / HIV
Colon trouble
Diabetes
Convulsions / Epilepsy
Cancer
Heartburn
Prostate problems
Bed wetting
Hepatitis (A, B, C)

Ulcers
Kidney trouble
Liver trouble
Gall bladder trouble
Digestive problems
Diarrhea / Constipation
Skin problems
Frequent colds / flu
Tremors
Allergies
ADD / ADHD
Sinus problems
Eating disorder
Learning disability
Dizziness
Jaw pain, TMJ, RL
Ringing in ears
Hearing loss
Fainting
Loss of balance / Vertigo
Blurred vision
Ear infection
Double vision