Patient Intake Form

for Chiropractic Care at Infinite Healing

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. On a daily basis we experience stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us an idea of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Section A: Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ Postal Code: _____

Driver's License Number: _____ E-mail: _____

Home: (____)_____ Cell: (____)_____ Work: (____)_____ Ext:_____

Date of Birth: M_____ D_____ YR_____ Age: _____ Male ☐ Female ☐

Single ☐ Married ☐ Divorced ☐ Widowed ☐ # of Children: _____

Is there a chance you are pregnant? Yes ☐ No ☐

Business / Employer: _____ Occupation: _____

How did you hear about our office? _____

Section B: Your Current Health

Check any of the following symptoms you have had in the last **12 months**, even if they do not seem related to your current problem(s).

☐ Lower back pain	☐ Headaches/Migraines	☐ Sciatica	☐ Cancer
☐ Shoulder pain	☐ Shin splints	☐ Digestive problems	☐ Diabetes
☐ Elbow pain	☐ Fatigue	☐ Ankle/foot pain	☐ Asthma
☐ Neck pain	☐ Ringing in the ears	☐ Hand/wrist pain	☐ Arthritis
☐ Knee pain	☐ Weight loss	☐ Difficulty sleeping	☐ Obesity
☐ Dizziness/Vertigo	☐ Flat feet	☐ Calluses/Bunions	☐ Achilles tendonitis
☐ Heart disease/Pacemaker		☐ Pain between shoulder blades	
☐ High Blood Pressure		☐ Tension across top of shoulders	
☐ Numbness or Tingling in hands/arms		☐ Numbness or Tingling in legs/feet	

OTHER: _____

Which of the above is the worst? _____

How long have you had it? _____ When is it at its worst? _____

How does it feel? (Sharp / Dull / Achy / Pins & Needles / Numbness)

_____

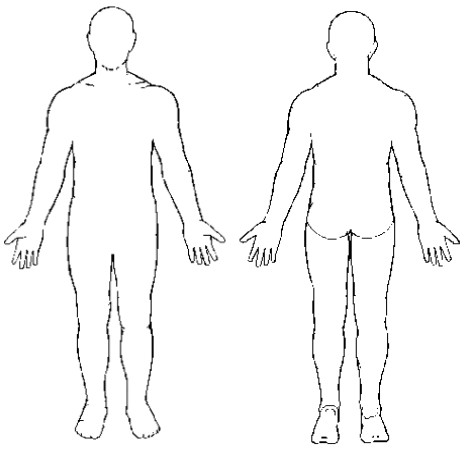
Does it interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Professionals you have seen for this problem: ☐ Chiropractor ☐ Physiotherapist ☐ MD

☐ Other (Please specify): _____

Section C: Growth / Development & Current Health Habits

	Yes	No	Please explain:
Medications?	☐	☐	_____
Have you ever had surgery?	☐	☐	_____
Do/Did you smoke?	☐	☐	_____
Do/Did you drink alcohol?	☐	☐	_____
Do/Did you take recreational drugs?	☐	☐	_____
Have you ever been in any accidents as a child?	☐	☐	_____
Have you ever been in any accidents as an adult?	☐	☐	_____
Vaccinations?	☐	☐	_____
As a child were you under regular chiropractic care?	☐	☐	_____
Do you play any sports?	☐	☐	_____
Do you participate in extreme sports?	☐	☐	_____
Are you physically active?	☐	☐	_____
Would you be interested in becoming more active?	☐	☐	_____



Mark where the problem is on the diagram with an X or a circle, and please describe what it feels like.

Sharp / Dull / Achy / Stabbing

_____
_____
_____
_____
_____
_____
_____
_____

Please circle the choice that best describes your:

Stress Level:	High	Moderate	Low
Diet:	Excellent	Good	Poor
Exercise:	Excellent	Good	Poor
Sleep:	Excellent	Good	Poor
General Health	Excellent	Good	Poor

Is this condition: ☐ Job related / WSIB ☐ Motor Vehicle Accident

(If you have answered YES to either of these questions, PLEASE INFORM THE FRONT DESK)

Section D:

Medical Doctor/Family Physician's Name: _____

Phone #: (_____)_____

Address: _____

_____

Section E:

Have you ever received chiropractic care? _____

If yes, how long ago? _____ How often did you go? _____

Chiropractor's name: _____ Phone #: (____)_____

Date of last visit: _____

Section F: Private Health Insurance

Do you have private health insurance / extended health care?

☐ Yes ☐ No

Insurance Provider: _____

Policy #: _____

ID #: _____

All the above information is true and accurate to the best of my knowledge.

_____ _____ _____

Printed Name **Signature** **Date**