



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: _____

OHIP CARD Number: _____ E-mail: _____

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

Date of Birth: M _____ D _____ YR _____ Age: _____ Male Female Other

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 Hip pain 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

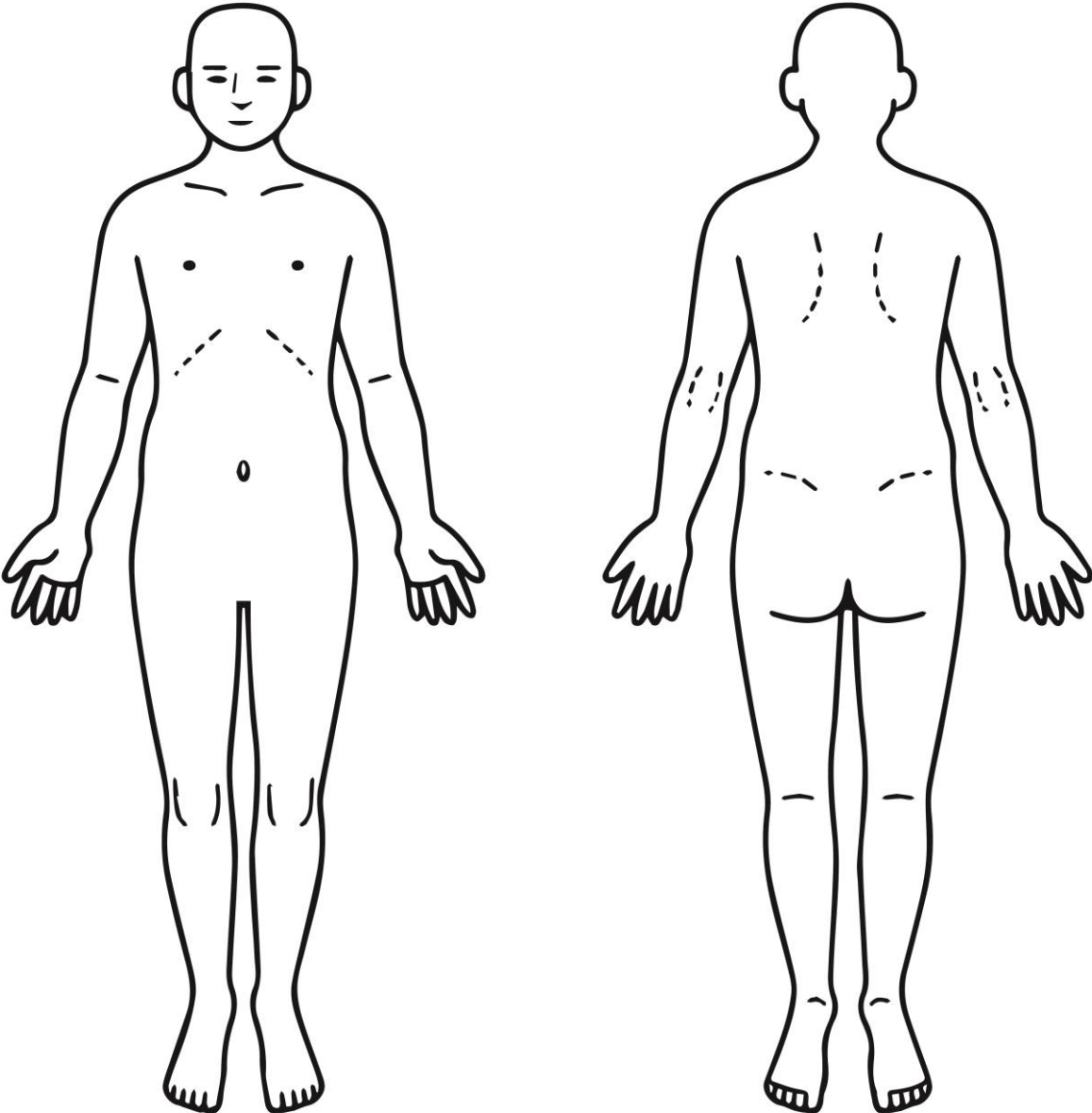
Professionals you have seen for this problem: Chiropractor Physiotherapist MD

Other (Please specify): _____

Section C: Growth / Development & Current Health Habits

	<u>Yes</u>	<u>No</u>	<u>Please explain:</u>
Do you suffer from mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Clinical Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder
Please provide details in the area provided:			<input type="checkbox"/> Other: _____
What medications are you on?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you take recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been in any accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been in any accidents as an adult?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaccinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you play any sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you physically active?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Would you be interested in becoming more active?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear orthotics (custom insoles)?			How old are they? _____
Do you wear compression socks?			_____
How old is your pillow? _____			Months Years
How old is your mattress? _____			Months Years
Do you sleep on your side back front ?			
How much water do you drink in a day? _____			

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



Notes:

