BRENTWOOD CHIROPRACTIC CLINIC

Move Better. Feel Better. Live Better.

ADULT INTAKE FORM

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Male / Female
Address: _____ City: _____ Province: _____ Postal Code: _____
Alberta Healthcare #: _____
Home Telephone #: _____ Work #: _____ Cell #: _____
Email: _____*by adding your email address you consent to receiving electronic reminders*
Marital Status: __Single __Married __Widowed __Divorced
Number of Children: _____ Children's Names (Ages): _____
Occupation: _____ Name of Business: _____
Emergency Contact Name and Number: _____
How did you hear about our clinic? _____

Do you have a recent motor vehicle injury claim? __Yes __No
Is this a work related injury/accident? (WCB) __Yes __No

REASON FOR VISIT

Reason for attending office:_____
Location of pain: _____
When did you notice it? _____ How often does it occur?_____
Does it radiate? **Yes** **No** If yes, where?: _____
What relieves it?_____
What aggravates it? _____
Describe how it interferes with your life, work, or hobbies? _____
_____
When have you had this or a similar condition in the past?
Is the condition getting worse? __Yes __No __Constant __Comes and Goes
Have you had previous chiropractic care? **Yes** **No**
Where? _____ When?_____ X-rays taken? **Yes** **No**
Other treatments tried: _____
How long has it been since you felt really good?_____

HEALTH HISTORY

Please check if you presently have or have had any of the following conditions in the past:

__Blurring of Vision
__Stroke
__Dizziness
__Depression
__Heart Disease
__Aneurysm
__Varicose Veins
__ Cancer
__Bronchitis
__Asthma
__Tendonitis
__Chest Pains
__Diabetes
__Hiatus Hernia
__Constipation
__ Arthritis
__Diarrhea
__Stomach Ulcer
__Heart Burn
__Headaches
__Allergies
__Sinusitis
__Ringing in Ears
__Osteoporosis
__Insomnia
__Respiratory Condition
__Urinary Frequency
__Lower Back Pain
__High Blood Pressure
__Menstrual Problems
__Numbness or Tingling in Arms or Legs

Patient Name: _____ Date: _____

Any family health conditions? **Yes** **No** Please list:_____
Other health problems? _____
_____
List surgical operations or hospitalizations and years they occurred: _____
_____
Pregnancies? _____
List of medications or vitamins you now take: _____
_____

Rate your diet:	__ Poor	__ Fair	__ Medium	__ Good	__Excellent
Rate your sleep habits:	__ Poor	__ Fair	__ Medium	__ Good	__Excellent
Rate your exercise:	__ Poor	__ Fair	__ Medium	__ Good	__Excellent
Rate your mental state:	__ Poor	__ Fair	__ Medium	__ Good	__Excellent

List and describe any auto accidents or other accidents/injuries: _____
_____
_____
List and describe any childhood injuries/accidents/hospitalizations/illnesses: _____
_____
Anything else you feel we should know about? _____
_____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Mark your levels of pain (0 being least, 10 the worst)

Today: 0----------10
Average: 0----------10

Numbness

● ●
● ●
● ●

Pins & Needles

○ ○
○ ○
○ ○

Burning

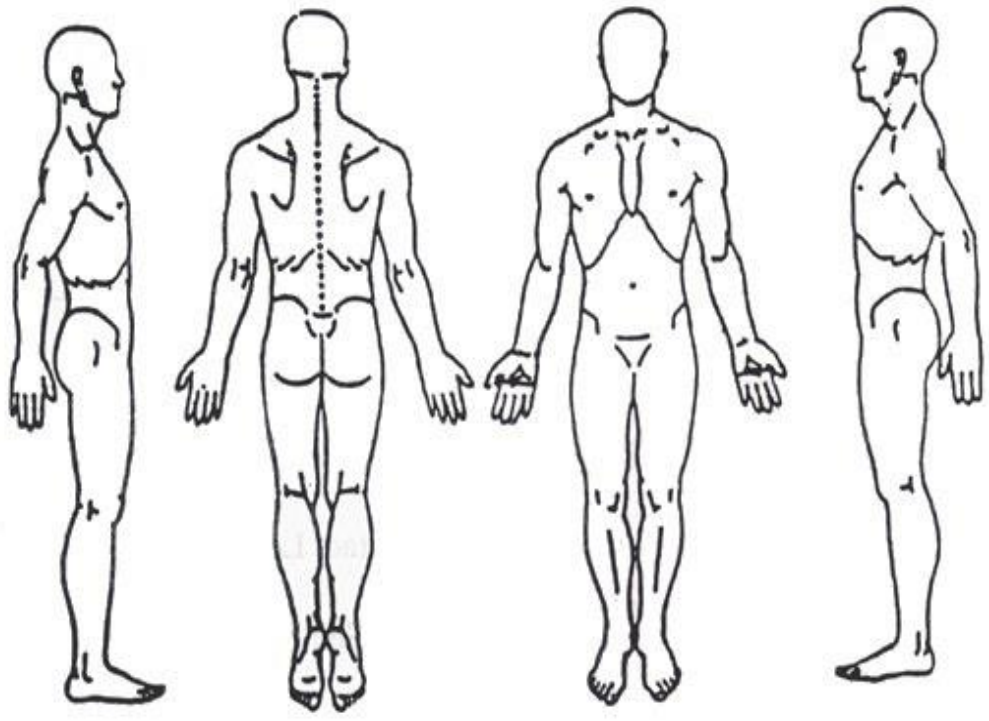
X X
X X
X X

Aching

* *
* *
* *

Stabbing

/ /
/ /
/ /



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