BRENTWOOD CHIROPRACTIC CLINIC

Move Better. Feel Better. Live Better.

Date: ____________________

Acupuncture Intake Form

Name: ____Date of Birth: ________________Age: ________ Male / Female

Address: ____

Home Phone #: ____________________________ Cell #: _____________________________________

Email: ____ (by adding your email address you consent to receiving electronic reminder notices)

Primary Physician: __________________________________ Phone: _____________________

Have you ever used: [ ]Chiropractic [ ]Acupuncture [ ]Homeopathy [ ]Chinese Medicine

If yes for what conditions? ____

____

Please provide the reason for your visit today:

____

____

____

____

Have you consulted with a physician or dentist (as appropriate) about the condition for which treatment is now being sought? [ ]Yes [ ]No

Physician's name: ____

What was their diagnosis, if any?

____

____

Please list any medications or nutritional substances you are currently taking (including cannabis or CBD oil):

____

____

____

____

Please list any known allergies:

____
____
____

Lifestyle:

Describe your family - number of people who live with you and their relationship to you.

Marital Status: __Married __Single __Widowed __ Divorced __ Separated

Children: How many? _____ Ages: ____

Other - describe: ____

Appetite: [ ]Low [ ]Moderate [ ]High Thirst for Water: [ ] No [ ] Yes _____ Glasses/day

Coffee: [ ] No [ ] Yes _____Cups/day Soda Pop: [ ] No [ ] Yes _____ Glasses/day

Alcohol: [ ] No [ ] Yes ____ servings/day Smoking: [ ] No [ ] Yes____ cigarettes (cigars)/day Yes Cravings for

Sugar: [ ] No [ ] Yes Cravings for Salt: [ ] No [ ] Yes

Artificial Sweeteners: [ ] No [ ] Yes - type____

Exercise: [ ]None [ ]Light [ ]Moderate [ ]Active [ ]Very Active [ ]Elite Athlete

Type of exercise: ____

Operations and Procedures

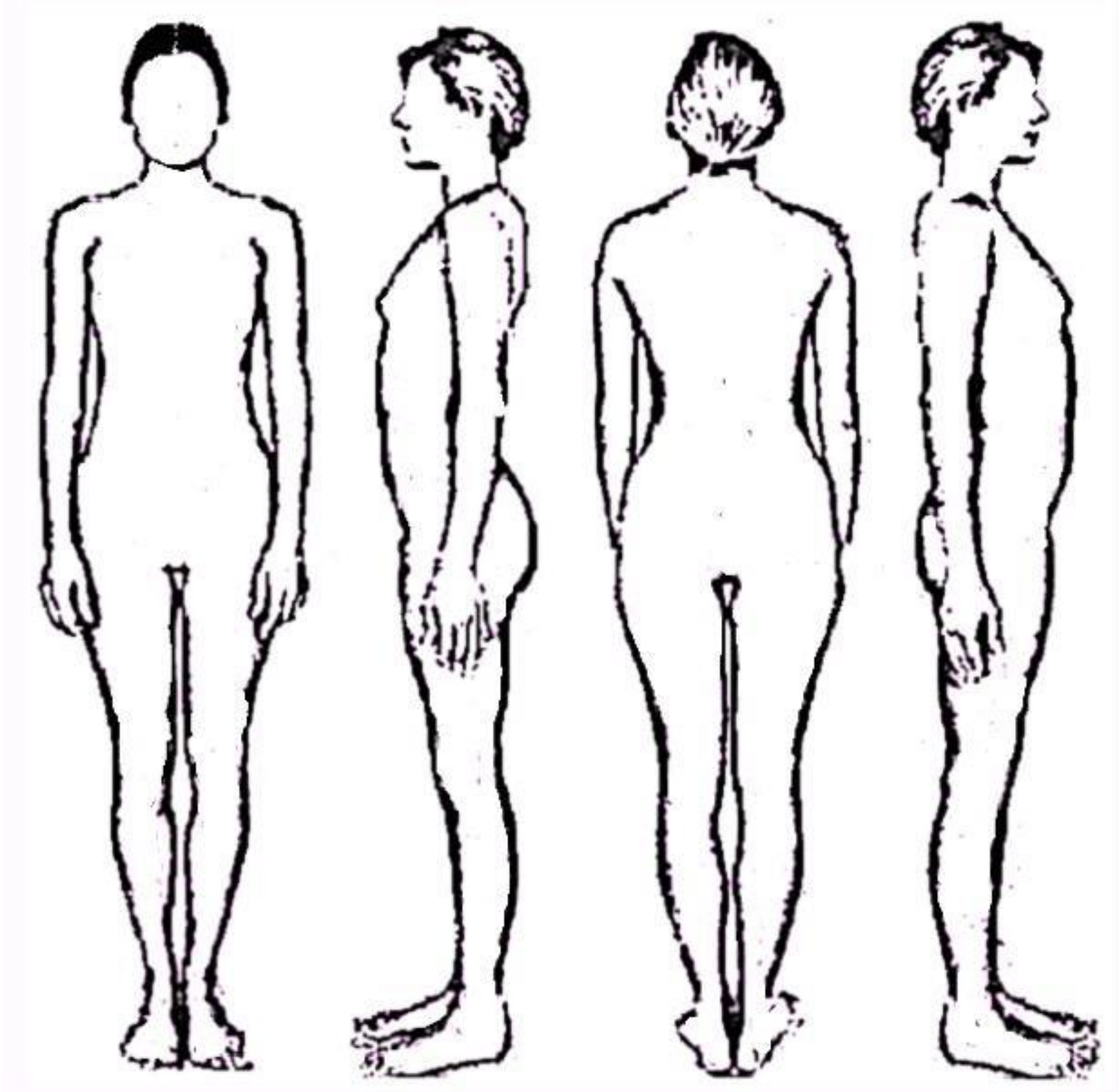
Please list any operations or procedures you have had:

____
____
____
____
____

Patient Name: ____________________________ Date: _______________________

Please circle areas of pain or discomfort and mark them using the following codes:

N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness



Dr. Roger G. Jones - Dr. Craig Breckenridge - Dr. Taylor Cooksley
#108, 937 Fir St. Sherwood Park, AB T8A 4N6 - 780-467-0892 - Fax: 780-467-9835
www.brentwoodchiropractic.ca Follow us on Facebook @ Brentwood-Chiropractic-Clinic

Patient Name: ____________________________ Date: _______________________

Do you have or have you ever had:
[ ] Osteoarthritis [ ] Bone Spurs [ ] Bulging Disc [ ] Fracture [ ] Tendonitis [ ] Herniated Disc
[ ] Joint Separation [ ] Sprains

If yes to any, please list the frequency and severity of the condition listed above on a scale of 1 to 5;

Frequency:

1 - 20% of the time, 2 - 40% of the time, 3 - 60% of the time, 4 - 80% of the time, 5 - 100% of the time

Area/location of area giving difficulty	Frequency (% of time this bothers you)	Severity of Condition 1-5	Getting Worse? Yes or No

List and date any accidents or falls:
____
____
____

Any additional comments concerning your condition/s:
____
____
____
____