East Central Chiropractic & Rehabilitation Intake Form

Last Name:		First Name:
Date of Birth:	Age:	Administrative Gender: M / F
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )
Appointment Reminders? Yes / No	If yes, please check: Email ☐ (requires phone provider) Text ☐	Mobile Phone Provider:
Email address: (optional)		(Email will be used for reminders and receipts)
Emergency Contact Name:		Emergency Contact Phone ( )
Alberta Health Care #:		Third Party Insurer Name:
Policy Holder:		Relationship to Policy Holder:
Group/ Policy #:		ID/ Certificate #:

Please check all answers and fill in the blanks where appropriate.

Is this a work related injury or WCB claim? Yes No Has your employer been notified? Yes No
Is this a Motor Vehicle Accident (MVA)? Yes No On what date did the accident occur? ______

Reason(s) for appointment: ____
When did your condition begin? ____

Have you ever had similar problems? Yes No Have you ever been treated for this problem? Yes No
If yes, please describe what did or did not work for you: ______________________________
Have you had previous chiropractic care? Yes No Dr. ______________ Date: ______________
If yes, please describe what did or did not work for you: ______________________________

Have you had X-rays, MRI, blood work or other tests for this condition? Yes No Which tests, when? _____
____

Can you perform daily home activities? Yes Yes, but only with help Not at all
Can you perform your daily work activities? All activities Only some activities Not at all
What is your occupation & regular duties? ______________________________________
Describe your stress level None Mild Moderate High
Do you exercise? Yes No What kinds of exercise do you do? ______________________

Family doctor name: Dr. ____
Do you give consent to allow us to contact your medical doctor/clinic if needed? Yes No
Height: _____________ Weight: _____________ Blood Pressure: _____________

Name: *(please print)*

Please list all previous surgeries, traumas, illnesses, injuries, accidents (including motor vehicle accidents):

___

___

Please list all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: ___

___

___

Please list all allergies: ___

___

Personal & Family Medical History

Please circle if you or your immediate family (parents, grandparents, siblings) have had any of the following conditions:

Myself		**Family Member**	
Cancer	Heart Disease	Cancer	Heart Disease
Stroke	Diabetes	Stroke	Diabetes
Hypertension	High Cholesterol	Hypertension	High Cholesterol
Epilepsy	Other: ___	Epilepsy	Other: ___
None of the above		None of the above	

Is there any other relevant information you feel should be discussed? Yes No

Please describe: ___

___

___

___

___

___

I concede that the above information is complete and correct to the best of my knowledge. I agree to notify my chiropractor at this clinic immediately of any health changes in the future

Date: ___ Patient signature: ___

Name: *(please print)*

Systems Review

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.
Put an “X” through each of the sections if you have not experienced any of the listed symptoms.

GENERAL SYMPTOMS

Fever
Sweats
Fainting
Sleep disturbance
Fatigue
Nervousness
Weight loss
Weight gain

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Wheezing
Difficulty breathing
Asthma
Allergies

GENITOURINARY

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Prostate trouble
Uncontrollable urine flow

NEUROLOGICAL

Visual disturbance
Dizziness
Fainting/Dropping to flor
Convulsions
Tremors
Headache
Numbness
Neuralgia (nerve pain)
Poor/loss coordination
Weakness
Concussion

CARDIOVASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Swollen ankles
Poor circulation
Palpitations
Cold hand or feet
Varicose veins
Bleeding disorder

GASTROINTESTINAL

Poor/Loss appetite
Difficult digestion
Heartburn
Ulcers
Nausea
Vomiting
Constipation
Diarrhea
Blood in stool
Gallbladder/jaundice
Colitis

EYES, EARS, NOSE, THROAT

Eye pain
Double vision
Blurred vision
Ringing in ears
Deafness/hearing problems
Nosebleeds
Trouble speaking/swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

MISCELLANEOUS

Depression
Anxiety
Diabetes
Infection
Hepatitis A/B/C
HIV/AIDS
Prostrate trouble
Rashes/Itches
Psychological disorder

MUSCLE & JOINT

Neck pain
Jaw pain
Low back pain
Midback pain (between shouldes)
Arm/hand pain
Shoulder pain
Leg pain
Knee pain
Ankle/foot pain
Pain/numbness down arms or legs
Swollen joints
Spinal curvature
Arthritis (Osteoarthritis, rheumatoid arthritis, gout)
Fracutres

FOR WOMEN ONLY

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week?
Other:

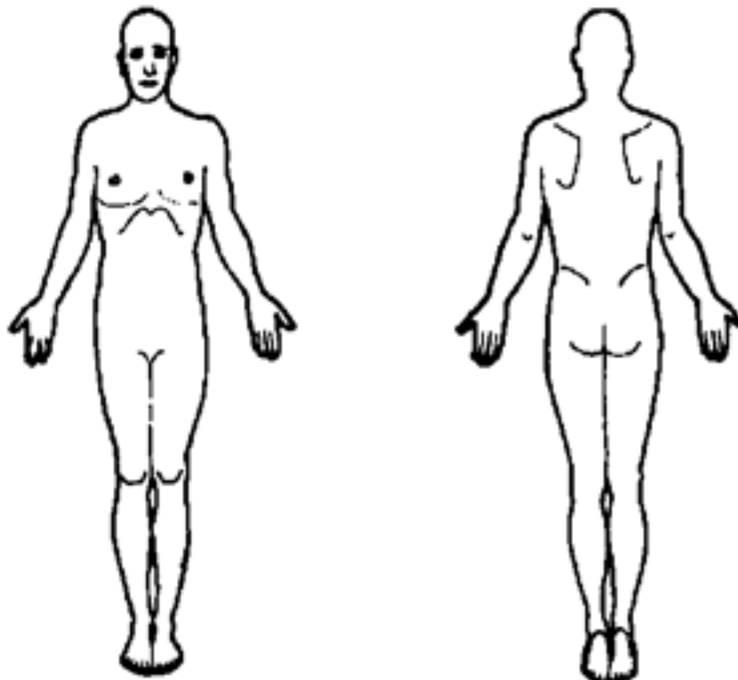
Name: *(please print)*

Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---Yes --No
2. Hardening of the arteries (arteriosclerosis) ----------------------------Yes --No
3. Diabetes --Yes --No
4. Tuberculosis --Yes --No
5. Cancer --Yes --No
   Where? ____
6. Heart or blood diseases ---Yes --No
7. Bone spurs on the neck bones (cervical sprain) ------------------------Yes --No
8. Whiplash injury (flexion-extension injury, cervical sprain)-----------Yes --No
9. Have you or any of your relatives ever suffered a stroke? -----------Yes --No
10. Were you ever a smoker? --Yes --No
    From ___________________ to ________________
11. Do you take medication on a regular basis? ----------------------------Yes --No
12. Visual disturbances (blurring, loss, double vision)---------------------Yes --No
13. Hearing disturbances (loss, ringing, other noise) ---------------------Yes --No
14. Slurred speech or other speech problems ------------------------------Yes --No
15. Difficulty swallowing ---Yes --No
16. Dizziness --- --Yes --No
17. Loss of consciousness, even momentary blackouts -------------------Yes --No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------Yes --No
19. Sudden collapse without loss of consciousness-------------------------Yes --No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain — Extreme pain