RIVERVIEW chiropractic clinic

Intake Sheet

Personal History

Legal Name: _____ Preferred Pronouns: _____

Preferred Name (if different than above): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth date: _____ Age: _____ Gender: ☐Male ☐Female ☐Non-Binary

E-mail: _____ A.H.C.: _____

Communication Preferences/Consents (please note you may choose to opt out at any time):
☐ I would like email reminders (sent 2 days before appointment)
☐ I would like text message (SMS) reminders (sent 1 day before appointment)
☐ I would like email notifications of new, cancelled, and rescheduled appointments
☐ I would like to receive news and special promotions by email
☐ I choose to opt out of all email and text message (SMS) notifications

Business/Employer: _____ Business Phone: _____

Occupation/Job Title: _____

Circle One: Married Single Widowed Divorced Separated Other

Number of Children: _____

Emergency Contact: _____ Phone number: _____

Relationship: _____

Who may we thank for referring you to this office?

_____

Do you have Extended Healthcare Coverage (EHC)? ☐Yes ☐No

Insurance Company: _____

Policy/Group Number: _____ Certificate/ID Number: _____

Riverview Chiropractic Clinic can store credit card information on file through our patient system, Jane. If you would like to store a credit card on file to assist with faster balance processing (recommended), please present a valid credit card to the receptionist.
Please note that Jane does not store your credit card information but rather it creates a reference token and the information is stored through Jane's high security payment partner, Stripe.

Current Health Condition

Main Complaint(s)/Reason for Visit:

_____

How did this condition begin? _____ ☐ I don't know

Is the condition: ☐ Job-related ☐Auto-related ☐Home-injury ☐Accident ☐Fall ☐ Other: _____

When did this condition begin? _____ ☐< 3 months ☐ < 6 months ☐ <9 months ☐1 year or more

Have you had this before? ☐Yes ☐No

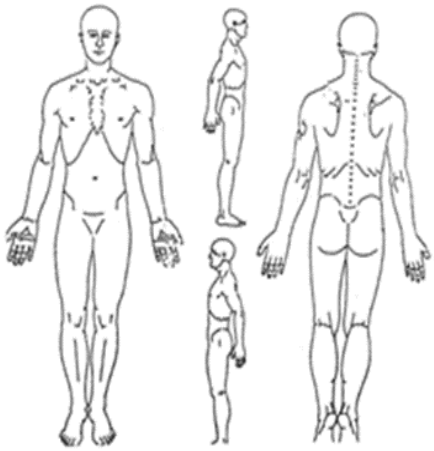
Have you had any care so far for this condition? ☐Yes ☐No

Who? ☐ Family MD ☐Physical Therapist ☐Chiropractor ☐Massage Therapist ☐Naturopath ☐Other_____

Type of Treatment: _____ Results: _____

Please indicate where your pain is on the diagram:

Please note the nature of the pain on the diagram:
Numbness ----------
Pins and needles ooooooo
Burning XXXX
Aching AAAA
Stabbing ////////



What increases your pain? ☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking ☐Lying Down ☐Cold ☐Dampness ☐Other: _____

What decreases your decreases your pain? ☐Bed Rest ☐Ice ☐Heat ☐Massage ☐Medication ☐Other: _____

Frequency of pain: ☐Constant ☐Intermittent ☐Seldom ☐Improving ☐Worsening

The pain feels: ☐Sharp ☐Dull ☐Ache ☐Pins & Needles ☐Numbness ☐Burning ☐Throbbing

Does the pain radiate or travel? If so, where? _____

Please describe how it feels when this problem is at its worse:

_____

Please circle the severity of your current pain:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Is there a specific time of day the pain occurs? _____

Do you have any other conditions that you'd like us to treat you for?

_____

Have you had imaging taken in the last six months? ☐Yes ☐No

If yes, where and what? _____

Health History

Medications/Supplements:
☐Nerve Pills ☐Painkillers ☐Muscle Relaxants ☐Blood Pressure ☐Cholesterol ☐Insulin
☐Other: _____
_____
_____
_____
_____

Major Surgery/Operations:
☐Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Hernia ☐Back Surgery
☐Broken Bones: _____ ☐Other: _____

Previous:
☐ Childhood Traumas: _____ ☐ Sports Injuries: _____
☐ Motor Vehicle Collisions: _____ ☐ Work Injuries: _____
☐ Falls: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: ☐None ☐Doctors name: _____

Approximate date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Would you like us to send a letter regarding today's assessment to your family physician? ☐Yes ☐No

Is there any family history of: cancer, diabetes, heart disease, stroke, hypertension, autoimmune disease (ex: scleroderma, rheumatoid arthritis), arthritic diseases (ex: osteoarthritis, degenerative joint disease, gout, polymyalgia), and/or progressive neurological disease (ex: multiple sclerosis, Parkinson's)? If yes to any of these, please record who and any extra details you can provide:

_____
_____
_____

Please indicate any other health issues that are present in your family:

Parents: _____

Siblings: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past:

Nervous System
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Musculoskeletal
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing / Clicking Jaw
- ☐ General Stiffness

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Female /Male
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction
- ☐ Menstrual Cramping

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Gas / Bloating After Meals
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Diarrhea

Genito – Urinary
- ☐ Bladder trouble
- ☐ Painful / Excessive Urine

Gastro-Intestinal
- ☐ Frequent Nausea
- ☐ Vomiting

☐ **None of these apply to me**

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Thyroid
- ☐ Eczema

☐ **None of these apply to me**

Have you experienced any of the following <u>in the past 6 months</u>?

- ☐ Cancer
- ☐ Confusion or altered consciousness
- ☐ Connective tissue disease
- ☐ Concussion
- ☐ Osteopenia
- ☐ Severe nocturnal pain
- ☐ Significant trauma or infection
- ☐ Unexplained weight loss
- ☐ Unexplained or novel neck pain
- ☐ Visual or speech disturbances
- ☐ Weakness or loss of sensation
- ☐ "Worst headache ever" or new headache, unlike any previous
- ☐ Have you experienced or have you been told you display abnormal sensory, motor, or deep tendon reflexes?
- ☐ Fever > 100°F
- ☐ Nuchal or midline neck pain when you bend your head forward
- ☐ Pain pattern unrelated to movement or activities

☐ **None of these apply to me**

Why Chiropractic Care?

People go to a chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative care – Life Enhancement and Wellness Care
- ☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
- ☐ Check here you want the doctor to select the type of care appropriate for your condition

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays.

I have had an opportunity to discuss with the doctor of chiropractic/staff member and/ or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment; including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then no, is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____ _____

Name Date