RIVERVIEW chiropractic clinic

Intake Sheet

Personal History

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Cell #: _____ Work #: _____ Home #:_____

Birth date: _____ Age: _____ Gender: ☐Male ☐Female

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

Business/Employer: _____Business Phone: _____

Type of Work: _____

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?

_____

Current Health Condition

Main Complaint(s): _____

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

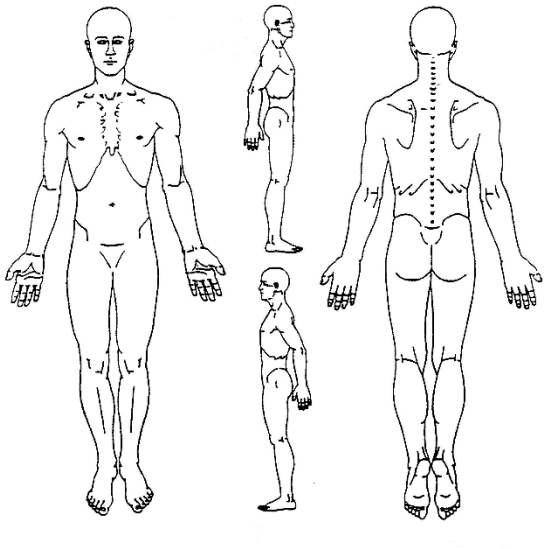
Have you had any care so far for this condition? ☐Yes ☐No

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

Type of Treatment: _____ Results: _____

Date of Accident: _____Time of Accident: _____

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: **////////**
If the pain travels, mark where it starts and where it travels to.

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

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

Is it getting: ☐Worse ☐Constant ☐Comes/Goes ☐Better

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

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**

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

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? (X-rays, MRI, CT, Etc.) ☐Yes ☐No

If yes, where and what? _____

Past Health History

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

Previous:
☐Childhood Traumas: _____ ☐Sports Injuries: _____
☐Motor Vehicle Accidents: _____ ☐Work Injuries: _____

Hospitalization (other than above):_____

Previous Chiropractic Care: ☐None ☐Doctors name: _____

Approximate date of Last Visit: _____

Family Health History

Name of Family Physician: _____

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

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐No ☐Yes whom? _____

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 six months:

Nervous System
- ☐Nervous
- ☐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

Gastro-Intestinal
- ☐Frequent Nausea
- ☐Vomiting

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

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

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.

_____ _____

Signature of patient (or legal guardian) **Date**