PEAK HEALTH
& PERFORMANCE

# Chiropractic Intake Form

## Patient Information
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**Date:** ........ DD/MM/YYYY **Full Name:** ........ **Preferred Name:** ........

**Sex:** ☐ Male ☐ Female **Birthdate:** ........ DD/MM/YYYY **Age:** ........ **Marital Status:** ........

**Alberta Health Care #:** ........ **Street Address:** ........

**Cell#:** ........ **Postal Code:** ........ **City:** ........ **Prov:** ........

**Home #:** ........ **Email:** ........

**Occupation:** ........ **Employer:** ........

**Emergency Contact:** ........ **Relationship:** ........ **Phone #:** ........

** We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address ?* ☐ Yes ☐ No

## Medical Information
2/10

**Family Medical Doctor's Name:** ........ **Clinic:** ........

**Date of last MD visit:** ........ **Reason:** ........

**Date of last physical examination:** ........

**What therapies have you previously received?** ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

** Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your medical doctor?* ☐ Yes ☐ No

## Extended Health Benefits & Other Insurance
3/10

**Do you have a private insurance plan?** ☐ No ☐ Yes (Self) ☐ Yes (Spouse) ☐ Yes (Parent)

**Name of primary policy holder (Spouse/Parent):** ........

**Policy #:** ........

**Member ID:** ........ **Group #:** (ABC Only) ........

**Is this a Workman's Compensation Case (WCB)?** ☐ No ☐ Yes

**Date of Accident:** ........

**Is this a Motor Vehicle Accident Case (MVA)?** ☐ No ☐ Yes

**Date of Accident:** ........

**Which Company?**

☐ Alberta Blue Cross (ABC) ☐ SunLife
☐ Great West Life ☐ Green Shield ☐ Standard Life
☐ SSQ Financial ☐ Chamber of Commerce ☐ Desjardins
☐ Cowan ☐ Industrial Alliance ☐ Johnson
☐ Manulife ☐ Other: ........

## How Did You Hear About Us?
4/10

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Street Sign
☐ Referred by Trainer ☐ Walk In ☐ Health Care Event ☐ Other: ........

*Whom may we thank for this referral? ........



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## Current Health Condition &/Or Injury



**Primary Complaint:** . . . . . . . . . . . . . . . . . . . . . . . . **When did this begin?** . . . . . . . . . . . . . . . . . . . . . .

**Have you had this before?** ☐ No ☐ Yes; When: . . . . . . . . . **Is it getting:** ☐ Worse ☐ Better ☐ Not Changing

**What is the character of the pain?** ☐ Dull & Achy ☐ Numb ☐ Stiff & Tight ☐ Pins & Needles ☐ Sharp ☐ Burning

**Is the Condition:** ☐ Work-Related ☐ Auto-Related ☐ Fall ☐ Sports-Related ☐ Other: . . . . . . . . . . . . . . . . . . . .

**Please rate your pain: (LEAST)** 0 1 2 3 4 5 6 7 8 9 10 **(WORST)**

**When do you feel the pain?** ☐ Constantly ☐ Intermittently ☐ Only at Night ☐ Only in the Morning

**Does the pain radiate down your legs or arms?** ☐ No ☐ Yes; Describe: . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Have you seen anyone else for this condition?** ☐ No ☐ Yes; Who: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Have you had any imaging for this condition:** ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date: . . . . . . . . . .

**What aggravates your pain?** ☐ Sitting ☐ Standing ☐ Rest ☐ Bending ☐ Lifting ☐ Exercise ☐ Weather Changes

**What relieves your pain?** ☐ Rest ☐ Movement ☐ Heat ☐ Ice ☐ Massage ☐ Medication: . . . . . . . . . . . . . . .

**Does this problem interfere with:** ☐ Work ☐ Family & Social Life ☐ Sports & Hobbies ☐ Sleep

**What is your commitment to correcting this problem:** 0 1 2 3 4 5 6 7 8 9 10

**Do you have any secondary complaints?** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

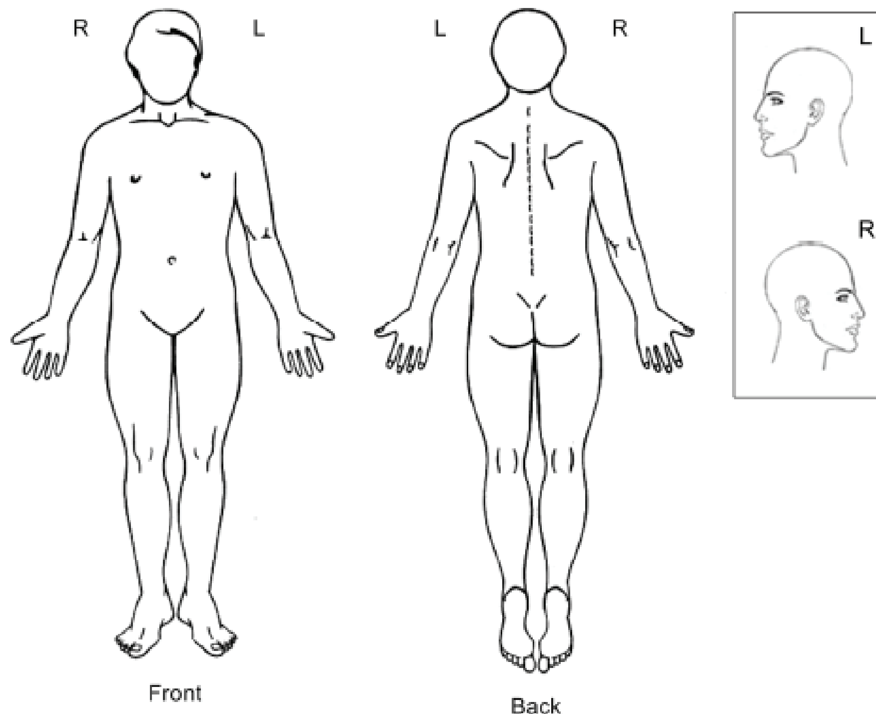
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

## Symptom Diagram



Please use the symbols below to mark all of the areas on the diagram that BEST represent the pain and sensations that you are CURRENTLY experiencing:

| Numbness | ==== | Pins/Needles | ~~~~ | Burning | oooo |
|---|---|---|---|---|---|
| Sharp | xxxx | Dull/Achy | ΔΔΔΔ | Stiff/Tight | 2222 |





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## Health History



**Have You Ever Had...**

**Fracture:** ☐ No ☐ Yes; where/ when: . . . . . . . . . . . . . .

**Major Surgery:** ☐ No ☐ Yes; where/when: . . . . . . . . . . . . .

**Car Accident:** ☐ No ☐ Yes; when: . . . . . . . . . . . . . . . .

**A Concussion:** ☐ No ☐ Yes; when/ how: . . . . . . . . . . . . .

**High Blood Pressure:** ☐ No ☐ Yes; when: . . . . . . . . . . . . .

**High Cholesterol:** ☐ No ☐ Yes; when: . . . . . . . . . . . . .

**Are you pregnant?** ☐ No ☐ Yes; Due Date: . . . . . . . .

**# of Past Pregnancies:** . . . . . . . . **# of Children:** . . . . . . . .

**Been Hospitalized:** ☐ No ☐ Yes; when/why: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Been Diagnosed With:** ☐ Cancer ☐ HIV/AIDS ☐ Hepatitis A/B/C ☐ Other: . . . . . . . . . When: . . . . . . . . . . .

**Do you have any allergies:** ☐ No ☐ Yes; List: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Please list any medications/supplements that you are *currently* taking:** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

## Family History



| **Is there a family history of:** | Heart Disease | Stroke | Cancer | Diabetes | Arthritis | Other |
|---|---|---|---|---|---|---|
| ***Mother's Side:** | ☐ | ☐ | ☐ | ☐ | ☐ | . . . . . . . . . . |
| ***Father's Side:** | ☐ | ☐ | ☐ | ☐ | ☐ | . . . . . . . . . . |

## Lifestyle



**Are you currently a smoker?** ☐ No ☐ Yes; amount: . . . . . . **Did you smoke previously?** ☐ No ☐ Yes; when: . . . . . .

**Do you exercise regularly?** ☐ No ☐ Yes; type & frequency: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Do you consume alcohol?** ☐ No ☐ Yes; amount/frequency: . . . . . . . . . . **Coffee?** ☐ No ☐ Yes; amount: . . . . . . . . . . .

**Do you have a healthy & balanced diet?** ☐ No ☐ Don't Know ☐ Yes, I think so ☐ Yes, definitely

**What are your stress levels?** ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐ Very Minimal

## Health Status Survey



**Please check the box of any conditions or symptoms that you have had in the past *six months*:**

**General:**
- ☐ Fever
- ☐ Fainting
- ☐ Night Pain
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Anxiety/Nervous
- ☐ Excessive Sweating

**Neurological:**
- ☐ Dizziness
- ☐ Paralysis
- ☐ Nausea
- ☐ Convulsions
- ☐ Clumsiness
- ☐ Blurred Vision
- ☐ Loss of Balance
- ☐ Numbness/Tingling

**Cardiovascular:**
- ☐ Angina
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Poor Circulation
- ☐ Previous Stroke
- ☐ Irregular Heartbeat
- ☐ Previous Heart Attack

**Respiratory:**
- ☐ Asthma
- ☐ Sore Throat
- ☐ Frequent Colds
- ☐ Chronic Cough
- ☐ Sinus Infections
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Difficulty Breathing

**Genitourinary:**
- ☐ Kidney Infection
- ☐ Menopause
- ☐ Painful Breasts
- ☐ Prostate Trouble
- ☐ Trouble Urinating
- ☐ Blood in Urine/Stool
- ☐ Painful Menstruation
- ☐ Irregular/Absent Cycle

**Eyes/Ears/Nose/Throat:**
- ☐ Eye Pain
- ☐ Ringing in Ears
- ☐ Worsening Vision
- ☐ Earaches/Infection
- ☐ Hearing Difficulty

**Muscle & Joint:**
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Elbow Pain
- ☐ Shoulder/Arm Pain
- ☐ Knee/Leg Pain
- ☐ Hip/Groin Pain
- ☐ Wrist/Hand Pain
- ☐ TMJ/Jaw Pain
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Disc Herniation
- ☐ Sciatica
- ☐ Ankle/Foot Pain
- ☐ Gout



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