PATIENT INTAKE FORM **DATE:_____**

NAME: _____PH#: H:_____ W:_____
STREET: _____CITY/TOWN: _____
PROVINCE: _____POSTAL CODE: _____BIRTHDATE: _____
AGE: _____ HT:_____ WT:_____ SEX: _____ OCCUPATION: _____
PHYSICIAN: _____REFERRED BY: _____ EMERG#:_____
E-MAIL:_____
MAIN PROBLEM:_____
_____
OTHER CONCURRENT THERAPIES: _____

PAST MEDICAL HISTORY (Include Date):
Significant illnesses: Cancer____Diabetes____High Blood Pressure____Heart Disease___Hepatitis____
Rheumatic Fever____ Thyroid Disease_____Seizures_____Other_____
Surgeries:
Significant Trauma (Auto accidents, falls, etc):_____
Birth History (prolonged labour, forceps delivery, etc.):_____
Allergies (drugs, chemicals, foods):_____
Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc:)_____
_____
Occupational Stresses (Chemical, physical, psychological, etc.):_____
Exercise: _____
Comments:_____

AVERAGE DAILY DIET:
Morning: Afternoon: Evening:

HABITS: Cigarettes____Coffee____Tea____Alcohol____Drugs____Sugar____Salt____Other_____
FAMILY MEDICAL HISTORY: Diabetes____Cancer____High Blood Pressure____Heart Disease_____
Stroke____Seizures____Asthma____Allergies____Alcoholism____Other_____
Notes:_____

GENERAL:
☐ Poor Appetite ☐ Heavy Appetite ☐ Poor Sleep ☐ Heavy Sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold Hands ☐ Cold Feet ☐ Cold back ☐ Cold abdomen
☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Sudden energy drop at_____(time) ☐ Peculiar tastes/smells
☐ Strong thirst (cold/hot drinks)

SKIN AND HAIR
☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Boils ☐ Psoriasis ☐ Herpes ☐ Shingles
☐ Change in hair/skin texture

HEAD, EYES, EARS, NOSE AND THROAT
☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses
☐ Eye Strain ☐ Eye pain ☐ Poor vision ☐ Night Blindness
☐ Colour blindness ☐ Cataracts ☐ Blurry Vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ copious saliva
☐ Teeth problems ☐ Jaw clicks ☐ grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ recurrent sore throats_____/month
☐ Sores on lips or tongue ☐ Headaches (where and when)_____
☐ Other head or neck problems:
☐ Glaucoma

CIRCULATORY

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficultly breathing ☐ other
☐ Varicose veins ☐ High cholesterol ☐ Mitral valve prolapse ☐ What's your blood type?

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm what colour_____ ☐ Other lung problems ☐ Smoking
☐ Environmental allergies

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____Frequency
☐ Bad Breath ☐ Rectal pain ☐ Hemorrhoids _____Colour
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____Odor
☐ Pain or cramps ☐ Laxative use:_____/week: type_____ _____Texture/form
☐ Gallstones ☐ Acid, reflux ☐ Appendix removed
☐ Diverticula ☐ Food allergies ☐ Bowel polyps
☐ Ulcers ☐ Blood sugar

GENIT-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often_____night:time ☐ Other G/U problems_____
☐ Bladder infections I drink _____cups water daily. ☐ My urine is yellow

PREGNANCY AND GYNAECOLOGY

☐ Number of pregnancies ☐ Number of births ☐ Premature births ☐ Miscarriages
☐ Age at first menses_____ ☐ Irregular periods ☐ Duration of menses___
☐ Clots ☐ Last menses_____ ☐ Flow describe _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps ☐ Menopause at age ____
☐ hysterectomy ☐ Sexually active ☐ Fertility problems ☐ Abnormal PAP
☐ Endometriosis ☐ Ovarian cysts ☐ Uterus fibroids ☐ Yeast infections
☐ Did you nurse your babies? ☐ Describe your PMS _____
☐ Birth control: type and duration

MUSCULOSKELETAL

☐ Neck pain ☐ Muscle pains ☐ Back pain (where)_____
☐ Joint pains (where)_____ ☐ Other joint or bone problems?_____
☐ Broken bones ☐ Disc problems ☐ Fibromyalgia ☐ Arthritis
☐ Injuries/accidents ☐ Never saw chiropractor

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Lack motivation ☐ Easily startled ☐ Early waking ☐ Considered/attempted suicide
☐ Treated for emotional problems ☐ Poor focus
☐ Wired & tired ☐ Can't concentrate ☐ Sigh frequently
☐ Other neurological or psychological problems? _____
☐ My hobbies are _____

IMMUNE SYSTEM

☐ Allergies ☐ Swollen glands ☐ I get flu shots ☐ I have pets
☐ Grinding teeth ☐ Fevers ☐ Autoimmune conditions I get_____colds
or flu per year. I use antibiotics_____per year. I travel _____per year, outside of Canada