New Patient Intake Form

Centre for Natural Pain Solutions

Name: _____ Date: _____

Address: _____

(Street) *(City)* *(Prov.)* *(Postal Code)*

Birth Date: d_____/m_____ /y_____ Age: _____

Marital Status: _____ Spouse/Partner's Name: _____

Occupation: _____ Business Name: _____

Phone Home #: _____ Daytime #:_____ Cell # _____

Email Address _____Receive news and updates via email Y N

Medical #: 6 digit _____ 9 digit _____ Social Assistance #: _____

3rd Party Health Insurance: Y N Insurance Company Name _____

Is this a: Worker's Compensation Claim? Y N Autopac Claim? Y N

How did you hear about the clinic? _____

Have you seen a Chiropractor before? Y N If Yes, who and when _____

Last Spinal X-Rays: m_____/y_____

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

I understand that I am responsible for full payment of fees and that fees are due prior to service

Patient Signature:_____ **Date:** _____

Witness: _____ **Date:** _____

PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing? _____
   _____

2. If this is a reoccurrence, when did you originally notice the problem? _____
   What initially caused it? _____

3. Has it changed recently? _____ Better _____ Worse _____ Same _____
   What types of treatment have you tried? _____
   _____
   What makes it better? _____ Worse? _____

4. How frequent is the condition? _____ How long does it last? _____

5. Is this affecting your sleep? Yes ___ No ____ If yes, please describe: _____
   _____

6. Is this affecting your ability to perform your job or daily activities? ___ Yes ___ No
   If yes, please describe: _____
   _____

7. Are there any other symptoms that may be related to these concerns that you have not listed?
   Yes ___ No _____ If yes please describe: _____
   _____

Please mark an "X" on the line to indicate the severity of your condition:

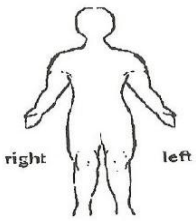
No Symptoms
Does not interfere with activities

Extreme Symptoms
Disabling

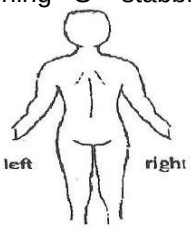
----------( )----------
<<<<<<<<<>>>>>>>>>

Please mark all areas of concern on the diagrams below:
N – numbness P – pins & needles B – burning A – aching S – stabbing.

Right Side



Front



Back

Left Side

Please circle all that apply.
Indicate whether this is a current or old concern by providing an approximate date.

1. General
fever
night sweats
nervousness/anxiety
bleeding
diabetes
thyroid
headache
fainting
depression
memory loss
chills
fatigue: AM/after lunch/ PM
weight loss/gain
anemia
cancer
substance abuse
dizziness
seizures
phobias
waking in night
problems falling asleep
hospitalizations:_____
_____
_____
any broken bones, car accidents or other injuries? _____
_____

2. Gastrointestinal
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other _____

3. Respiratory
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other _____

4. Cardiovascular
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other _____

5. Musculoskeletal
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other _____

6. Skin
rashes
mole changes
itching
nail changes
redness
other _____

7. EENT
blurry vision
double vision
eye pain
jaw pain
ringing in ears
ear infection
sinus problems
nose bleeds
throat problems
speech problems
glasses or contacts? _____

8. Genitourinary
frequent/painful urination
incontinence
blood in urine or stool
urinary infection
venereal infection
other _____

9. Women Only
difficult periods
hot flashes
irregular cycles
breast pain
difficulty becoming pregnant
complication of pregnancy
other _____
Date last period ended _____
Period begins every ____ days
Date of last gynecologic exam
_____

10. Men Only
testicular pain
prostate problems
difficult erection
low sperm count

11. Endocrine
heat/cold intolerant
sugar cravings
weight gain in abdomen
problems with missing a meal
better after meal
thyroid problems

12. Habits
water _____ cups/day
smoke _____ packs/day, years
alcohol _____ drinks/week
caffeine _____cups/day
recreational drug use _____

13. Family
Are your parents living? _____
If so do you consider them to be in good health? _____
Ages: Mother ____ Father _____

Circle any of the following that apply to your parents, siblings or children:
diabetes stroke hypertension cancer seizures tremors brain disorders
heart disease lung disease arthritis scoliosis thyroid

Is the condition due to injury or sickness arising out of employment?
_____

Is the condition due to injury or sickness arising out of an auto or other type of accident? _____

Number of days lost from work _____Date symptoms appeared or accident happened _____

Please list all doctors you have seen related to your current concern.

1. _____ 2. _____
3. _____ 4. _____

Allergies:

What drugs are you allergic to? _____
_____
_____

What environmental allergies affect you? _____
_____
_____

What foods are you allergic to? _____
_____
_____
_____
_____
_____
_____
_____

Please list any medications you have taken in the past year.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Signature: _____ Date: _____