Chiropractic Intake and History Form

Welcome to our office! Your careful completion of this form will help us to better care for your needs.

Date ______________________

Last Name ______________________ First Name ______________________ Middle Initial ______

Address ____

City ______________________ Province ______________________ Postal Code ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email ______________________ Preferred contact for reminders ☐ H ☐ C ☐ W ☐ Email

Date of Birth ______________ ☐ M ☐ F Alberta Health Care Number ______________

Is this a Worker's Compensation Injury? ☐ No ☐ Yes Is this a Motor Vehicle Accident Injury? ☐ No ☐ Yes

Occupation ______________________ Employer ______________________

Marital Status ☐ M ☐ S ☐ W ☐ D Spouse's Name & Phone ______________________

How did you hear about our office? ______________________________

Your major complaint/symptoms ______________________________

When and how did this condition start? ______________________________

How would you describe your pain? ☐ Sharp ☐ Burning ☐ Tightness ☐ Ache ☐ Searing ☐ Toothache ☐ Electrical ☐ Lightning ☐ Tingling ☐ Penetrating ☐ Other ______________

What aggravates your condition? ______________________________

Is the condition getting worse? ☐ No ☐ Yes ______________________________

What makes the condition better? ______________________________

Have you had this or a similar condition in the past? ☐ No ☐ Yes If yes, when? ______________

Are you seeing or have you seen any other health care provider for this condition?

☐ No ☐ Yes If yes, who and when? ______________________________

Have x-rays been taken of the area of complaint? ☐ No ☐ Yes If yes, when? ______________

Name of x-ray facility and location ______________________________

What medications are you currently taking? ______________________________

Any other complaints or symptoms? ______________________________

List any previous surgeries, illnesses, car accidents or work injuries ______________________________

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When was the last time you were hospitalized? ______________________________

For what reason? ______________________________

Have you had previous chiropractic care? ☐ No ☐ Yes If yes, when? ______________

What were you treated for? ______________ Chiropractor's Name ______________

Family/medical doctor's name ______________________________

Date of last physical exam ______________________________

Do you have any other health problems for which you are seeing your doctor? ☐ No ☐ Yes

If yes, please describe ______________________________ *(continued on other side →)*

If you have had ANY of the following complaints in the past year, please check:

Musculoskeletal
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Difficulty chewing
- ☐ Clicking jaw

Gastrointestinal
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea / vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Haemorrhoids
- ☐ Liver trouble
- ☐ Gas / bloating after meals
- ☐ Heartburn
- ☐ Black or bloody stool

Nervous System
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold extremities
- ☐ Tingling extremities

Cardiovascular/Respiratory
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems / congestion
- ☐ Varicose veins
- ☐ Ankle swelling

Eyes, Ears, Nose, Throat
- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earaches
- ☐ Hearing difficulties
- ☐ Stuffed Nose

Reproductive
- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain / infections
- ☐ Breast pain / lumps
- ☐ Prostate dysfunction
- ☐ Sexual dysfunction
- ☐ Genital herpes

Genitourinary
- ☐ Bladder trouble
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Discoloured urine

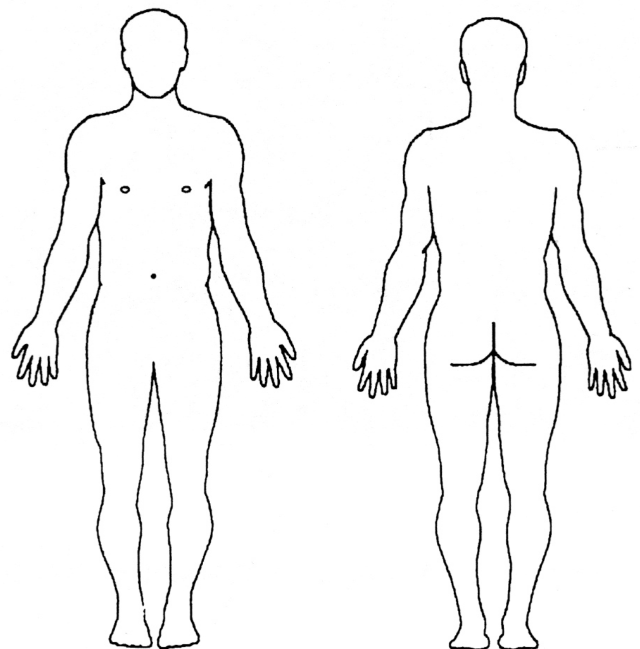
General
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headaches
- ☐ HIV

Females Only
Date of last period ____________________

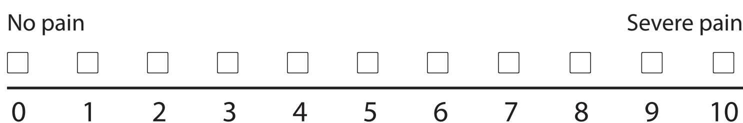
Are you pregnant? ☐ No ☐ Yes

If yes, due date ____________________

Tell us where you hurt
On the drawings, mark ALL areas where you feel pain. If the pain radiates, draw an arrow from where it starts to where it stops.



Pain scale
Please indicate the severity of your pain on the scale below.



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