CLINIC INTAKE FORM

SECTION 1 BASIC INFORMATION

Today's Date: _____

Name: _____ **Preferred Name:** _____ **Age:**____

Date of Birth (mm/dd/yyyy): _____ **Gender:** _____ **Care Card #:** _____

Address: _____ **City:** _____

Postal Code: _____ **Phone #(s):** _____

Occupation: _____ **Employer:** _____

Spouse's Name: _____ **Names of children (ages):** _____

How did you hear about our office? Referred by: _____

❑ **Online Search** ❑ **FaceBook** ❑ **Twitter** ❑ **Phone Book**

SECTION 2 APPOINTMENT REMINDERS (e-mail/text) & RECEIPTS (email):

Email _____ **Cell #:** _____ **Cell Provider:**_____

Preferred method of reminder: **email** _____ **text** _____ **both** _____

Please note that we cannot do telephone reminders – reminders are done through the computer
Reminders are complimentary and not to be relied upon.

SECTION 3 HEALTH PROFILE

Are you or might you be pregnant? ❑ Yes ❑ No If yes, due date? _____

GROWTH & DEVELOPMENT

		Please Describe
Was your birth traumatic?	Y / N	_____
Have any serious falls or accidents?	Y / N	_____
Have recurrent childhood illness/sickness?	Y / N	_____
Experience other serious traumas/stress?	Y / N	_____

CURRENT HEALTH HABITS

Eat healthy foods regularly?	Y / N	_____
Drink 8-10 cups of water daily?	Y / N	_____
Exercise regularly?	Y / N	_____
Smoke?	Y / N	_____
Have high mental stress?	Y / N	_____
Have high physical stress?	Y / N	_____
Have any serious or chronic past injuries?	Y / N	_____
Have sleeping problems?	Y / N	_____
Sleeping position: side; stomach; back	_____	_____
Have you been in any car accidents?	Y / N	When? _____

SECTION 4 FAMILY HEALTH PROFILE

	Arthritis	*Cancer*	*Diabetes*	*Heart Disease*	*High Blood Pres.*	*Strokes*	*Other* _____
Your father's side	❑	❑	❑	❑	❑	❑	❑ _____
Your mother's side	❑	❑	❑	❑	❑	❑	❑ _____
Your children	❑	❑	❑	❑	❑	❑	❑

SECTION 5 MEDICAL INFO:

Who is your medical doctor? _____

If you are taking medications, please list them. Side effects from drugs / surgery?

Med: _____ Reason? _____ For how long? _____ _____
Med: _____ Reason? _____ For how long? _____ _____
Med: _____ Reason? _____ For how long? _____ _____

If you have had any surgeries, please list them.

Surgery: _____ Reason? _____ Date: _____
Surgery: _____ Reason? _____ Date: _____

Please turn over

SECTION 6 PRESENT COMPLAINTS (Please skip this section if ICBC or WCB)

PLEASE NOTE: if this is related to ICBC or WorkSafe, skip this section and continue to Section 7. ICBC or WorkSafe-specific forms must also be filled out.

Present Complaint (Reason for your visit today):

_____

_____

Pain or problem started how and when? _____

_____

What activities make your condition / pain worse? _____

_____

What activities make your condition / pain better? _____

_____

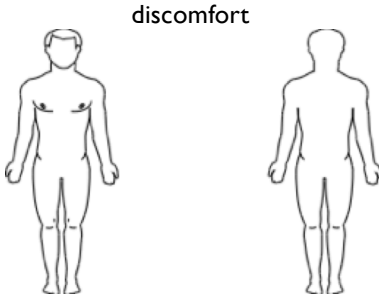
If you have pain, is it… ❑ sharp ❑ dull ❑ radiating ❑ constant ❑ intermittent
❑ mild ❑ moderate ❑ mod-severe ❑ severe

Since it began, is it… ❑ the same ❑ variable ❑ better ❑ worse

What time of day is worst? ❑ waking ❑ at work ❑ evening
❑ at night ❑ variable ❑ constant

Does it interfere with… ❑ work ❑ sleep ❑ walking
❑ sitting ❑ exercise ❑ other

Please mark the area(s) of your discomfort



OTHER TESTS: (please circle)
Have you ever had:
X-rays / CT scan / MRI
Neck / Back / Hips/pelvis
If yes, how long ago?
Less than 7 yrs / More than 7yrs

Do you remember what the results were? _____

_____

_____

_____

_____

SECTION 7 CURRENT SYMPTOMS: (Even if they do not seem related to your current condition):

❑ headaches / migraines	❑ dizziness / vertigo	❑ sinus problems / allergies	❑ high blood pressure
❑ neck stiffness / pain	❑ fatigue	❑ shortness of breath	❑ heart problems / stroke
❑ shoulder stiffness / pain	❑ sleeping problems	❑ constipation / diarrhea	❑ cancer
❑ pins & needles in arms	❑ tension / stress	❑ problems urinating	❑ diabetes
❑ numbness in fingers	❑ nervousness / anxiety	❑ cold sweats	❑ recurring infection
❑ back stiffness / pain	❑ irritability / mood swings	❑ hot flashes	❑ loss of smell / taste
❑ pins & needles in legs	❑ depression	❑ menopause	❑ vision changes
❑ numbness in feet / toes	❑ stomach upset	❑ PMS / menstrual cramps	❑ buzzing / ringing in ears
❑ foot problems	❑ heartburn / reflux	❑ infertility / impotence	❑ loss of balance
❑ jaw / TMJ problems	❑ ulcers	❑ cold hands / feet	❑ chest pains

❑ other _____

SECTION 8 OTHER TREATMENT:

Have you seen another practitioner and if so who & when? (Please list.)

❑ chiropractor _____ ❑ physiotherapist _____
❑ massage therapist _____ ❑ reflexologist _____
❑ acupuncturist _____ ❑ other _____

PLEASE NOTE

- ***Your appointment time is reserved for you. Please allow 24 hours notice to cancel or reschedule, otherwise a charge of 100% of the booked treatment fee will be applied to you.*** _____Initial
- ***At Pitt Meadows Wellness, we are a team; your file and information will be accessible by all practitioners including Chiropractors, Physiotherapists, Acupuncturists and Registered Massage Therapists at our clinic.*** _____Initial
- ***If you have requested an electronic reminder, your signature below also gives us consent through the Canadian Anti-Spam Law to proceed with the reminder. We will not share or sell any of your personal information.*** _____Initial

_____ _____
Signature Date