



1180 FIR STREET CAMPBELL RIVER, BC V9W 3B8
250-287-8487

CONFIDENTIAL PATIENT INTAKE FORM

Date: _____

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Cell: _____ Work: _____

Email: _____

Birth Date (D/M/Y): _____ Age: _____ Sex: M F Marital Status: S M D W
 S

Your Occupation: _____ How long? _____

B.C. Care Card Personal Health Number: _____

How did you hear about our office? Friend or family member(who?): _____

Medical referral: _____ Yellow pages Sign Other: _____

ARE YOU OR WILL YOU BE ON ICBC OR WCB?:

- 1. Recent motor vehicle accident (ICBC): Yes No (if Yes, please see receptionist)
- 2. Work related injury/accident (WCB): Yes No (if Yes, please see receptionist)

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?: Yes No

If Yes who?: _____ And when? _____

Condition you were seen for?: _____

What results did you obtain with care?: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name: _____ Clinic: _____

Date of last Appointment: _____



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CURRENT HEALTH CONDITION

What health concern has brought you to our office? _____

Please describe the pain and it's location: _____

How long has this been bothering you? _____ Is it getting worse? Yes No Off and On Constant

Is this condition affecting your: Work Sleep Daily Routine? If yes please explain: _____

Have you had this or similar conditions in the past? Yes No If yes please explain: _____

What other treatment have you already received for your condition? Medication Surgery Physio Therapy
 Chiropractic Massage None Other: _____

HEALTH HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD BEFORE OR HAVE NOW:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Fever(prolonged) | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Menopause | <input type="checkbox"/> Severe Fall |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Midback Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Conditions | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> On Medication | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Painful Menses | Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | _____ |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Intestinal conditions | <input type="checkbox"/> Prostate problem | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis | |



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STRESS SURVEY

Please rate the following on a 10 point scale: 10 high/0 low

Physical STRESS level (posture, sitting, standing, lifting, twisting) /10
Chemical STRESS level (coffee, alcohol, cigarettes, drugs, diet) /10
Emotional STRESS level (deadlines, relationships, responsibilities) /10

Physical Activity Level: Not so good Good Great

How many times per week do you exercise? _____

Nutritional Intake: Not so good Good Great

Supplements: _____

Posture: Not so good Good Great Do you wear: Orthotics Heel lifts
Arch supports

Sleep: Not so good Good Great Age of mattress: _____

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time treatments are received, unless other arrangements are made in advance.

X _____
SIGNATURE DATE