Discovery CHIROPRACTIC

1241 Dogwood St.
Campbell River, BC
Canada, V9W 6C1

Phone : 250.287.8487
Email : info@discoverychiropractic.ca

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:

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

Other:_____
_____
_____

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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 incure in this office. All fees are payable at the time treatments are received, unless other arrangements are made in advance.

X_____
SIGNATURE DATE