FIRST CHIROPRACTIC & WELLNESS CLINIC

PDF Intake Form Directions

Due to the sensitivity of the following information, please do not send these forms via email.

Please print the following forms, complete them and bring them with you to your appointment.

You may also fax the forms to us at 306-691-4041

If you have any questions, please call us at 306-691-4040

First Chiropractic & Wellness Clinic
624 – 1st Avenue NW
Moose Jaw, SK S6H 3M6
306-691-4040

Confidential Patient Case History

Date: _____

INITIAL INFORMATION

Name: _____ **Sex:** M/F

Email: _____ **May we contact you by email?** yes/no

Height: _____ **Weight:** _____ **Birth Date (month/day/year):** _____

Who may we thank for referring you? _____

HEALTH HISTORY

Please mark the following conditions that you have presently with a check ☑ or have had in the past with an ☒.

GENERAL
□ Allergies
□ Weight Loss
□ Weight Gain
□ Skin Irritations
□ Sweats
□ Tremors
□ Chills
□ Fever

NEUROLOGICAL
□ Convulsions
□ Dizziness
□ Nausea
□ Numbness
□ Tingling Sensation
□ Nervousness/Depression
□ Burning Sensation
□ Headaches
□ Muscle Weakness

MUSCLE AND JOINT
□ Shoulder
□ Mid-back pain/stiffness
□ Knee
□ Hip
□ Elbow
□ Neck pain/stiffness
□ Ankle
□ Spinal curvature
□ Hand/wrist
□ Low back pain/stiffness
□ Foot

GENITO-URINARY
□ Kidney stones
□ Urinary tract infections
□ Painful urination
□ Frequent urination
□ Inability to control urination

GASTROINTESTINAL
□ Gall bladder problems
□ Liver trouble
□ Vomiting of blood
□ Hernia
□ Blood in stool
□ Inability to control bowel
Other digestive problems (specify):
_____

RESPIRATORY
□ Chest pain
□ Difficult breathing
□ Spitting up blood
□ Asthma
□ Coughing
Other respiratory problems (specify):
_____

CARDIOVASCULAR
□ Hardening of arteries
□ Poor circulation
□ High blood pressure
□ Cold extremities
□ Swelling of ankles
Other cardiovascular problems (specify):
_____

EYES, EARS, NOSE AND THROAT
□ Enlarged glands
□ Deafness/hearing loss
□ Enlarged thyroid
□ Trouble speaking
□ Problems swallowing
□ Falls due to poor balance
□ Blurred vision
Other problems in these areas (specify):
_____

FOR WOMEN ONLY
□ Hot flashes
□ Irregular cycle
□ Menopausal symptoms
□ Lumps in breasts
Are you pregnant? YES□ NO□
Other problems in these areas (specify):
_____

MALE ONLY
□ Prostate problems
□ Sexual dysfunction
□ Impotency
Other problems in these areas (specify):
_____

OTHER (specify):
_____
_____
_____
_____
_____
_____

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Circle the following conditions you presently have or have had in the past.

Alcoholism	Emphysema	Rheumatic fever	Polio	Cancer
Pneumonia	Ulcers	Gout	Anemia	Epilepsy
Stroke	Arteriosclerosis	Arthritis	Diabetes	Tuberculosis
Heart disease	Osteoporosis	Other (specify):_____		

1. Have you ever been to a chiropractor before? YES ☐ NO ☐

   If YES, approximately how long since your last visit? _____

2. Have you ever had any x-rays of your spine or neck taken? YES ☐ NO ☐

   If YES, approximately how long ago and at what facility? _____

3. Date of your last physical examination: _____

4. List previous diagnoses/serious illnesses you have had: _____

5. List any surgeries you have had: _____

6. Do you participate in a regular exercise program? YES ☐ NO ☐

   If YES, how often and what? _____

7. Do you drink coffee? YES ☐ NO ☐ Average cups per day? _____

8. Do you smoke? YES ☐ NO ☐ If YES, how many packs per day? _____

9. Do you think your appetite is: HEAVY ☐ MODERATE ☐ LIGHT ☐

10. Do you sleep well? YES ☐ NO ☐ In what position? BACK☐ STOMACH☐ SIDE☐

11. Medications you now take:

☐ None	☐ Pain killers	☐ Muscle relaxants	☐ Birth control pills
☐ Insulin	☐ Diuretic	☐ Antidepressants	☐ Blood thinners
☐ Anti-anxiety	☐ Sleeping pills		

   ☐ Other (specify): _____

12. Do you take any natural supplements such as a multi-vitamin? YES ☐ NO ☐

    If YES, what? _____

Have you ever experienced any of the following, even short temporary attacks?

1. Blurred or double vision YES ☐ NO ☐
2. Partial or complete loss of vision YES ☐ NO ☐
3. Ringing, buzzing or noise in ear(s) YES ☐ NO ☐
4. Hearing loss in one or both ears YES ☐ NO ☐
5. Slurred speech or other speech problems YES ☐ NO ☐
6. Difficulty swallowing YES ☐ NO ☐
7. Dizziness or sudden collapse YES ☐ NO ☐
8. Lack of understanding YES ☐ NO ☐
9. Loss of consciousness YES ☐ NO ☐
10. Numbness or loss of sensation YES ☐ NO ☐

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CURRENT HEALTH HISTORY

1. Briefly describe your current complaint/reason you came into the clinic: _____

   _____

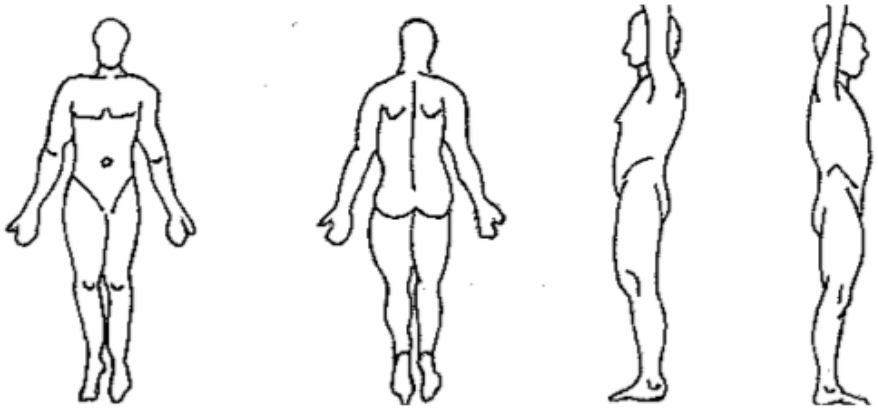
2. When did this condition begin? _____

3. Is the pain constant or intermittent? _____

4. What aggravates this condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
   ☐ Cold ☐ Dampness ☐ Other _____

5. What relieves this condition? ☐ Rest ☐ Ice ☐ Heat ☐ Medication ☐Other _____

6. Mark the areas on your body where you feel the described sensations. **Use the appropriate symbol**. Include all affected areas.



LEGEND:
A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

7. Mark in this scale your level of pain right now:

   (0 = no pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (10 = worst pain)

8. Reason for consulting this office:
   ☐ I have a specific health problem and require help only with this problem.
   ☐ After my specific problem has been managed, I am interested in strategies to optimize my health.
   ☐ I have no symptoms and I feel well. I am interested in strategies to help me to experience my full health potential.