



ADULT INTAKE

Name: _____ Today's Date: _____

Your Age: _____ Date of Birth: _____ Personal Health Number: _____

Address: _____ City/Prov: _____ Postal Code: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Occupation: _____

Insurance Company: _____ Employer: _____

Marital Status: M S D W SEP CL Spouse Name: _____

of Children & Ages: _____ Pregnant? Due Date: _____

How would you prefer we contact you for appointment reminders? Text Email Phone

Who can we thank for referring you to our office? _____

Emergency Contact Name: _____ #: _____ Relationship: _____

History of Complaint Please identify condition(s) that brought you here:

	Area of Concern i.e. Neck, low back, shoulder	Frequency Constant, daily, intermittent	Pain 0-10 10 = Severe	Relieves Symptoms i.e. Sitting, walking, etc.	Worsens Symptoms i.e. Sitting, walking, etc.
1					
2					
3					
4					

How did the injury(s) happen? _____

Are there any active claims relating to this injury with: ICBC Work Safe BC

Have you missed any work due to your injury? Y N If yes, please list the dates: _____

Have you seen another provider for this condition? Chiro Physio M.D. Specialist Other

Relevant History

When was your last visit to a chiropractor? _____ Chiropractor's Name: _____

What surgeries have you had? _____

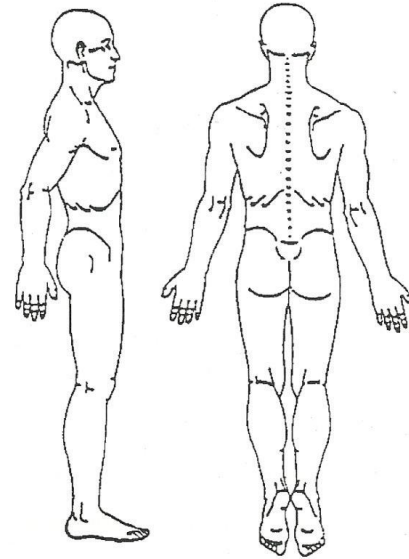
Any relevant injuries or illnesses? _____

List any drugs or supplements you are taking: _____

Symptom Diagram

Please mark areas on the diagram with the following bolded letters to describe your symptoms.

Radiating	Burning	Aching
Numbness	Sharp/Stabbing	Tingling



Hereditary Diseases

Has anyone in your immediate family had any of the following conditions?

Heart Disease	Heart Attack	Diabetes
Cancer	Spine Problem	Alzheimer's
Multiple Sclerosis	Mental Illness	High Blood Pressure
Muscular Dystrophy	Stroke	Arthritis

Symptom Diagram – Please check any that apply.

Neck Pain	Trouble sleeping	Ulcers
Numb / Tingling pain (upper)	High/Low blood pressure	Gall bladder trouble
Numb / Tingling pain (lower)	Anemia	Digestive problems
Upper back pain	Asthma	Frequent colds / flu
Mid back pain	Difficulty breathing	Tremors
Lower back pain	Stroke	Allergies
Shoulder pain	Chest pain	ADD / ADHD
Headache	Impotence / Sexual dysfunction	Sinus problems
Hip pain/Pelvic pain	Currently pregnant	Eating disorder
Diff. Standing, walking or sitting	PMS	Learning disability
Difficulty exercising	Menstrual problems	Dizziness
Fractured bones	Colon trouble	Jaw pain, TMJ, RL
Motor Vehicle Collisions	Diabetes	Ringing in ears
Accidents / Falls	Convulsions / Epilepsy	Hearing loss
Back curvature/Scoliosis	Cancer	Fainting
Arthritis	Heartburn	Loss of balance
Swollen / Painful joints	Prostate problems	Vertigo
Pain w/ coughing/sneezing	Bed wetting	Visual disturbance
Foot trouble	Hepatitis (A, B, C)	Ear infection
