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

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

Relevant History

Please list known allergies (medications, foods, lotions, oils) ________________________________

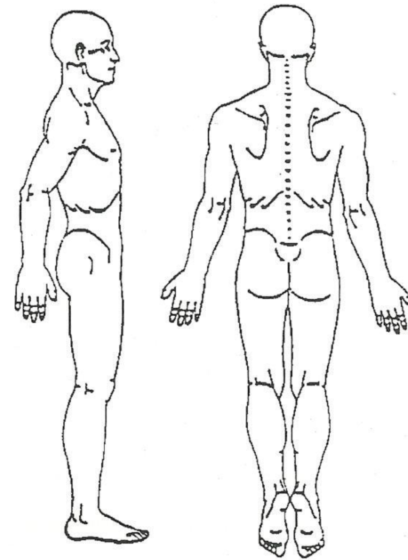
What surgeries have you had? ____

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	**B**urning	**A**ching
Numbness	**S**harp/Stabbing	**T**ingling

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	Joint dislocation	Implants
Numb / Tingling pain (upper)	Trouble sleeping	Transplants
Numb / Tingling pain (lower)	High/Low blood pressure	Rods/Pins/Plates/Shunts
Upper back pain	Heart Attack	Tremors
Mid back pain	Pacemaker	Allergies
Lower back pain	Chest pain	ADD / ADHD
Shoulder pain	Stroke / Aneurysm	Eating disorder
Headache / Migraine	Convulsions / Epilepsy	Anxiety / Depression
Hip pain/Pelvic pain	Cancer	Dizziness / Fainting
Diff. Standing, walking or sitting	Heartburn	Jaw pain, TMJ, RL
Difficulty exercising	Bruise easily	Ringing in ears
Fractured bones	Varicose veins	Hearing loss
Motor Vehicle Collisions	Other circulatory condition	Loss of balance
Accidents / Falls	Diabetes	Vertigo
Back curvature/Scoliosis	Skin condition	Visual disturbance
Arthritis	Digestive condition	Ear infection
Osteoporosis	Sinus problems	Hepatitis (A, B, C)
Swollen / Painful joints	Frequent colds / flu	HIV
Pain w/ coughing/sneezing	Nausea	Other contagious condition

____

____

____

____

____