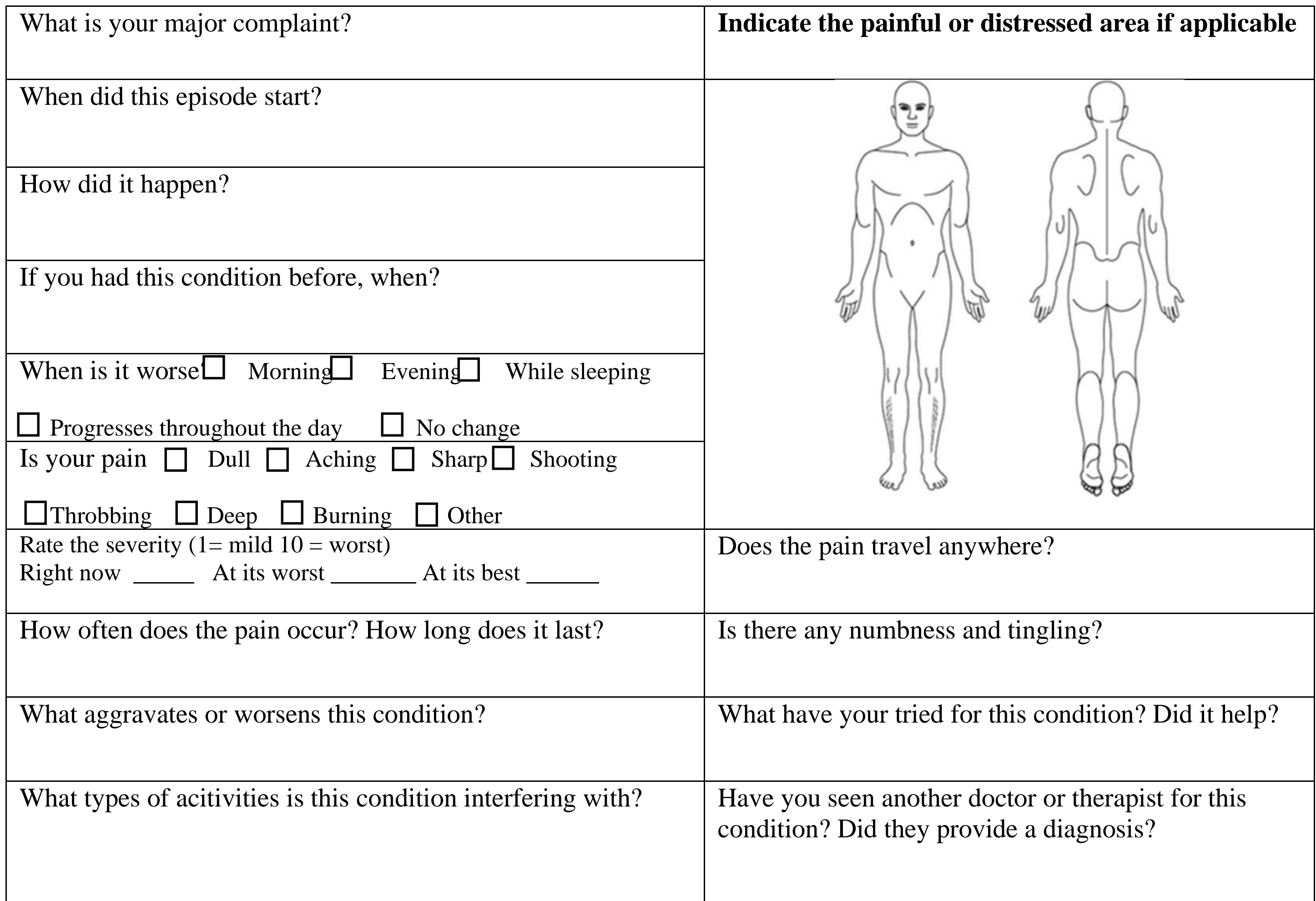
ALL SYSTEMS
WELLNESS • CHIROPRACTIC • NATUROPATHY

CONFIDENTIAL PATIENT INTAKE CHIROPRACTIC/MASSAGE

Full Name:		Date of birth:
Cell Phone Number:		Home Phone Number:
Address:		
City:	Postal Code:	Province:
Email Address:		
Occupation:	Employer:	
Name of Emergency Contact:		Number:
How did you hear about the clinic:		

Health Concerns

Please help us understand what brings you into the office today.

What is your major complaint?	**Indicate the painful or distressed area if applicable**
When did this episode start?	
How did it happen?	
If you had this condition before, when?	
When is it worse ☐ Morning ☐ Evening ☐ While sleeping ☐ Progresses throughout the day ☐ No change	
Is your pain ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Deep ☐ Burning ☐ Other	
Rate the severity (1= mild 10 = worst) Right now _____ At its worst _______ At its best ______	Does the pain travel anywhere?
How often does the pain occur? How long does it last?	Is there any numbness and tingling?
What aggravates or worsens this condition?	What have your tried for this condition? Did it help?
What types of acitivities is this condition interfering with?	Have you seen another doctor or therapist for this condition? Did they provide a diagnosis?

General Symptoms	Eyes/Ears/Nose/Throat	Gastrointestinal	Skin
☐ Loss of Consciousness ☐ Blackouts ☐ Headache ☐ Fever ☐ Excess sweating ☐ Weight Loss ☐ Generalized pain ☐ Nervousness ☐ Convulsions ☐ Loss of sleep	☐ Failing vision ☐ Eye pain ☐ Failing hearing ☐ Earache ☐ Ring/buss in ears ☐ Frequent colds ☐ Sinus infection ☐ Enlarged thyroid ☐ Enlarged glands	☐ Poor appetite ☐ Indigestion ☐ Hunger ☐ Belching/gas ☐ Stomach pain ☐ Diarrhea ☐ Constipation ☐ Jaundice ☐ Ulcer	☐ Rashes/itching ☐ Bruise easy ☐ Dryness ☐ Boils ☐ Hives (allergies)
Neurologic	**Cardiovascular**	Currently on birth control? Yes__ No ___	Previously on birth control? Yes__ No ___
☐ Dizziness ☐ Fainting ☐ Problem speaking ☐ Problem swallowing ☐ Blurred vision ☐ Double vision ☐ Nausea ☐ Clumsiness ☐ Numbness/tingling	☐ Bleeding disorder ☐ High blood pressure ☐ Chest pain ☐ Stroke ☐ Hardening of arteries ☐ Varicose veins ☐ Swelling of ankles ☐ Poor circulation ☐ Heart/blood disease ☐ Angina	# of pregnancies __ # of children ____ Have you ever been diagnosed with: Cancer? Yes___ No ___ HIV/Aids? Yes __ No ___ Hep A/B/C? Yes__ No ___	
Muscles and Joints	**Genitourinary**	Have you ever had any fractures?	
☐ Sore/stiff neck ☐ Mid back ache ☐ Low back ache ☐ Painful tailbone ☐ Shoulder pain ☐ Arm/forearm pain ☐ Elbow pain ☐ Wrist/hand pain ☐ Hip pain ☐ Knee pain ☐ Ankle/foot pain ☐ Arthritis ☐ Loss of strength	☐ Trouble urinating ☐ Blood in urinary ☐ Kidney infection ☐ Bedwetting ☐ Prostate trouble **GU for women** ☐ Painful menstruation ☐ Excessive flow ☐ Hot flashes ☐ Irregular/absent cycle ☐ Cramping/backache ☐ Vaginal discharge ☐ Swollen breasts ☐ Lump in breasts	Yes__ No ___ If yes where? _____________ Have you ever been in a car accident? Yes ___ No___ If yes when? _____________ Have you ever been hospitalized? Yes___ No___ If yes why/when? _______________________________ _______________________________ Are you a current smoker? Yes ___ No___ How much? ______ Former smoker? Yes __ No ___	
Respiratory	**Medications? (list)**		
☐ Asthma ☐ Chronic cough ☐ Spitting up phlegm ☐ Spitting up blood ☐ Difficulty breathing			

Do you consent to a professional & complete examination by our chiropractor and/or massage therapist?

Signature ____ Date _____________________