Body + Spine Chiropractic Intake Forms

Date____________

Contact Information

First Name ____________________ Last name ______________________

Gender _____ Referred by ________________

Email _____________________________

Telephone: Home____________ Cell______________ Work_____________

Address_______________________________________ City____________

Province_______ Postal Code ___________

Age_____ Birth date _____________ Marital Status_____________

Children_____ Occupation ______________________________

Emergency Contact_____________________ Phone __________________

Current Complaints

Please describe the reason you are seeking care at Body + Spine:

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Nature of injury: Automobile_______ Work_______ Other_______

Date of injury _______________

Date symptoms appeared________________

Have you ever had the same condition before? No_____ Yes_____

If yes, when? ____

List of other practitioners seen for this injury ________________________________

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Have you ever been under chiropractic care? No______ Yes______

If yes, please describe ____

Insurance Information

Do you have health insurance? No______ Yes______

Name of insurance company ____

Medical History

Have you been treated for any conditions in the last year? No _____ Yes _____

If yes, please describe ____

Date of last physical exam_________

Is there a chance that you are pregnant? No___ Yes ___

Have you had X- rays taken? No____ Yes ____ Where? ______________

What medications are you taking and for what conditions (please list dosage and amounts, etc.)? ____

What vitamins, minerals, or herbs do you currently take? Please list for what conditions, dosage, and frequency____

Have You Ever

	No	Yes	Explain
Had broken bones?			
Been hospitalized?			
Been in an auto accident?			
Had sprains/ strains?			
Been struck unconscious?			
Had surgery?			

Family History

Immediate family members- present and past health conditions (example: heart disease, cancer, diabetes, arthritis, etc.)

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Pain Symptoms

	No	Yes	Explain
Do you experience pain every day?			
Do your symptoms interfere with daily life?			
Does pain wake you up at night?			
Are your symptoms worse during certain times of the day?			
Do changes in weather affect your symptoms?			
Do you wear orthotics?			
Do you take vitamin supplements?			
What activities aggravate your symptoms?			

Daily Life

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol				
Coffee				
Tobacco				
Drugs				

Exercise				
Sleep				
Appetite				

Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Is there anything else you would like to add?

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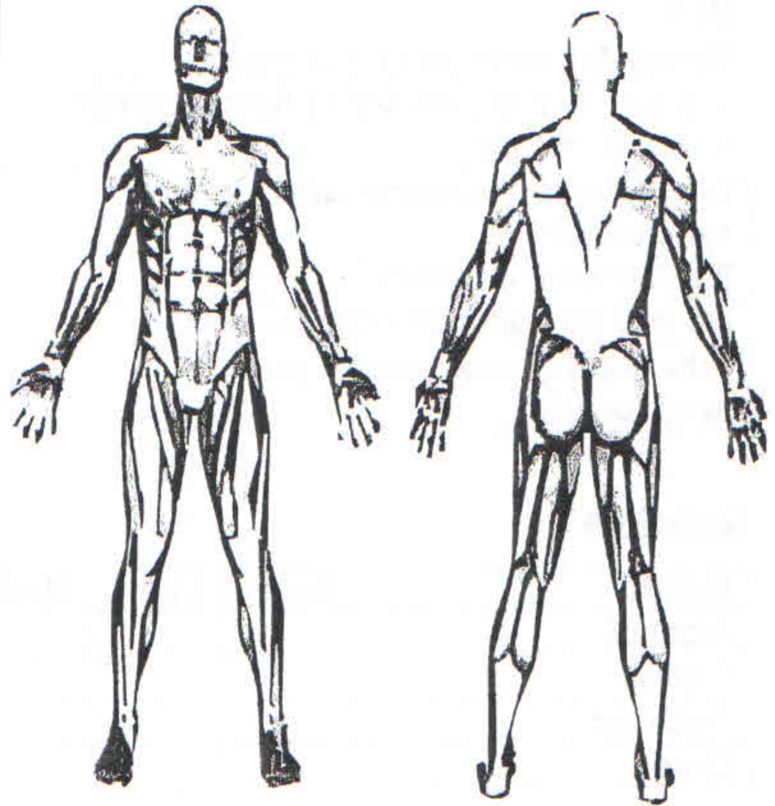
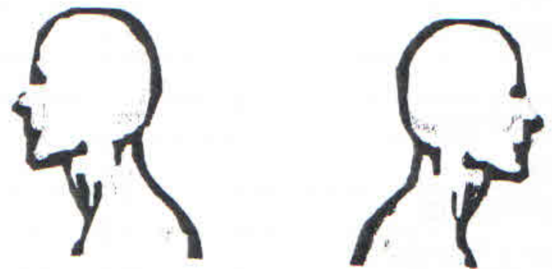
Have you ever suffered from:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/Conditions
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ears Ring
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Loss of memory
- [ ] Loss of balance
- [ ] Loss of smell
- [ ] Loss of taste
- [ ] Lumps In Breast
- [ ] Neck Pain or Stiffness
- [ ] Nervousness
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Sciatica
- [ ] Shortness of breath
- [ ] Sinus Infection
- [ ] Sleep problems or Insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other: ____________

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing





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