CHIROPRACTIC PATIENT INTAKE FORM

PERSONAL INFORMATION

TITLE: MR.☐ MRS.☐ MISS.☐ MS.☐ DR.☐				DATE:
FIRST NAME	INITIAL	LAST NAME		HEIGHT : WEIGHT:
ADDRESS	APT #	CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE:	CELLUAR TELEPHONE:	EMAIL ADDRESS:	OCCUPATION:	
BIRTH DATE DAY/MONTH/YEAR	SEX ASSIGNED AT BIRTH:	HOW DID YOU HEAR ABOUT US?		
IN CASE OF EMERGENCY				
CONTACT NAME		TELEPHONE		RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ YES ☐ NO

DOCTOR'S NAME		DOCTOR'S TELEPHONE NUMBER		LAST VISIT
ADDRESS	SUITE	CITY	PROVINCE	POSTAL CODE
DO YOU HAVE ANY ALLERGIES	ARE YOU MAKING A CLAIM FOR 1) RECENT MOTOR VEHICLE ACCIDENT: ☐ YES☐ NO 2) WORK RELATED INJURY/ACCIDENT(WSIB) ☐ YES ☐ NO			

CHIROPRACTIC INFORMATION

REASON FOR SEEKING CHIROPRACTIC CARE TODAY?	HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?

HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFFESSIONAL? ☐ YES ☐ NO

TREATMENT RECIEVED

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO *IF YES PLEASE COMPLETE THE FOLLOWING:*

CHIROPRACTOR'S NAME:	LAST VISIT:
REASON FOR SEEKING CARE	RESULTS ☐ GOOD ☐ FAIR ☐ POOR

HEALTH INSURANCE

DO YOU HAVE PRIVATE HEALTH INSURANCE THROUGH A MEDICAL PLAN? NO ☐

☐ YES; MY OWN PLAN	☐ YES; MY SPOUSE'S PLAN D.OB	☐ YES; MY PARENTS PLAN D.O.B
COMPANY _____	COMPANY _____ ----------	COMPANY _____ _____
PLAN/POLICY # _____	PLAN/POLICY # _____	PLAN/POLICY # _____
ID/CER/EMP # _____	ID/CER/EMP # _____	ID/CER/EMP # _____

Please check "√" if you are experiencing the following symptoms. Please check all that apply.

General:
- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Loss of sleep
- ☐ Fever
- ☐ Nervousness
- ☐ Weight loss
- ☐ Excess sweating
- ☐ Night Sweats
- ☐ Night pain
- ☐ Generalized pain
- ☐ Headaches
- ☐ Convulsions

Neurologic:
- ☐ Dizziness
- ☐ Fainting
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Nausea
- ☐ Clumsiness
- ☐ Numbness & tingling

Muscles and Joints:
- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Upper limb pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Respiratory:
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up phlegm/blood

Genitourinary:
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

Cardiovascular:
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Gastrointestinal:
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorroids
- ☐ Jaundice
- ☐ Gallbladder trouble

GU for women:
- ☐ Menstruation issues
- ☐ Breast swelling/lump
- ☐ Hot flashes
- ☐ Vaginal discharge

Family history:
- ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Stroke ☐

Lifestyle:
- ☐ Smoking ☐ If so, how much?
- ☐ Alcohol ☐ If so, how much?
- ☐ Exercise ☐ If so, how often?
- ☐ Healthy diet ☐

List all past surgeries:

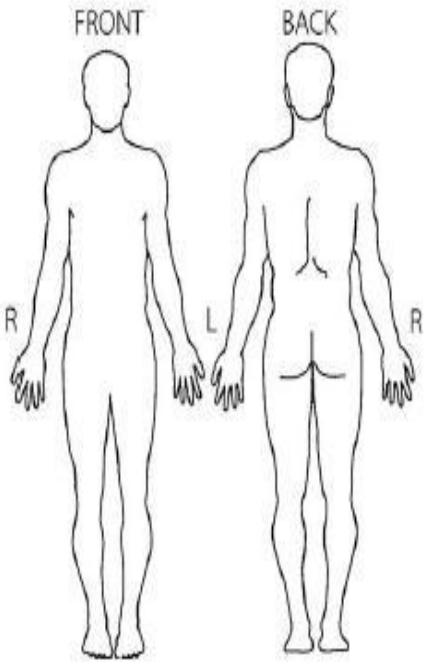
- ☐ Have you had any **past fractures**? ☐ Yes ☐ No
- ☐ If yes, where?

- ☐ Have you ever been diagnosed with:
- ☐ Cancer ☐ HIV/AIDS ☐ Hep A/B/C ☐

- ☐ List all prescription/over-the-counter **medications** and **supplements** you are presently taking:

- ☐ Women only: Are you Pregnant? ☐ Yes ☐ No
- ☐ Due Date:

CHIEF COMPLAINT



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

1

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	+++++	^^^^^^^	*****	///////////	====

2

How did your symptoms start?
- ☐ Sudden
- ☐ Gradual
- ☐ Car accident
- ☐ Work related injury

When did your symptoms start?
- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

3

Please mark on the line below the level or your discomfort

0 — No pain

10 — Worst pain

Direct Billing Policy

We offer direct billing to select insurance companies for your health care provided at Family Chiropractic Centre. This is not a mandatory service but a **courtesy to our clients**. We will try to directly bill only to those companies that may allow for it and for those policies that will pay the health care provider directly. If your insurance company/policy does not pay the provider directly then we will issue you a receipt on payment for you to submit to insurance yourself.

Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Family Chiropractic Centre. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment.

_____	_____	_____
Print name	Signature	Date

Privacy Policy

Your health care provider is responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and on-going treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be accessed by staff.

Cancellation Policy

To better serve our clients **we require at least 24 hours notice for changes or cancellations**. If you cancel within 24 hrs or you completely miss your appointment without cancelling, you may be charged the full amount of the session.

Reason: If we have notice, we may be able to fill your time slot with another client. As a courtesy, we will email a day in advance to remind you of your appointment, if you have provided that contact information.

I understand the above Policies and I agree they are fair and reasonable.

Signature:_____ Date:_____