

## CHIROPRACTIC INTAKE FORM

	2 300					-			-	Gender:	
Age	Date of Birth	D	м	Y		Tel.	No. (	_)_			
Address	American Company										
City			Province_			Р	ostal Code	5			
E-mail:							1-17	1			1
Occupation	a trade			Job Desc	ription			W			
Employer									How le	ong?	
Emergency contact	manife Burger										
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Reason for consultati	on:				1.						
ls your condition re			hicle injury/a			100	f Yes, con f Yes, con	No. of Contract of			
low has it affected yo	datha a st.										
□Concentration □D	riving DHou	se work	Mood Per								
□Concentration □D  Prior Treatment □	riving □Hou	se work	□Mood □Pen MD □Physio	□RMT				-			
□Concentration □D  Prior Treatment □  Examination: □ Yes □ P	riving DHou  Yes DChiro	practor   Yes   N	□Mood □Pers  MD □Physio  o Lab/Bloo	□RMT od test: □	Other	Other	; ;	2 2	in the second		_ □ No
Concentration D  Prior Treatment   Examination: Yes   Finding/Diagnosis:	riving □Hou  Yes □Chiro  No X-rays	practor D	□Mood □Per MD □Physio o Lab/Bloo	□RMT od test: □	Other Yes  No Treatmen	Other	,	2 2	erest _ 0 to	632 r 1615	_ □ No
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Use the symbols below to show area(s) of pain or discomfort; include all affected areas



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## **CHIROPRACTIC INTAKE FORM**

Stiffness: ++ Numbness: 00 Pins & Needles: \*\* Burning: XX Dull Ache: --Sharp Pain: || INTENSITY OF DISCOMFORT 10 None **Moderate Pain** Severe Excruciating When did it start? D \_\_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_ Is your discomfort ☐ Better ☐ Same ☐ Worse Possible cause \_\_\_ Primary daytime activity \_\_\_\_ Location ☐ Home ☐ Office ☐ School ☐ Other Work or study station ergonomic assessment □Yes □No % Walking \_\_\_ % Standing \_\_\_\_ Comment(s)\_ How did you find the clinic? ☐ Ad/Promo ☐ Clinic Sign ☐ Event ☐ Website ☐ Referral \_ Date D\_\_\_\_ Signature - Patient or Parent/Guardian