Physiotherapy
2 Orchard Heights Blvd., Suite #36, Aurora, ON L4G 3W3
P: 905.713.2427 F: 905.713.2910 E: info@lifespringclinics.ca
www.lifespringclinics.ca

CHIROPRACTIC INTAKE FORM

Name______________________________ Gender: ☐M ☐F

Age________ **Date of Birth** D________ M________ Y________ **Tel. No.** (______)__________

Address______________________________

City______________ Province______________ Postal Code______________

E-mail: ______________________________

Occupation______________ **Job Description** ______________

Employer______________ City______________ **How long?** ________

Emergency contact ______________ **Relationship** ________ **Tel** (______) __________

Reason for consultation: ______________________________

Is your condition related to a 1 Motor vehicle injury/accident ☐ Yes ☐ No *(if Yes, complete MVA form)*
2 Work related injury/accident ☐ Yes ☐ No *(if Yes, complete WSIB form)*

How has it affected your daily activities? ______________________________
☐Concentration ☐Driving ☐House work ☐Mood ☐Personal care ☐Recreation/Sports ☐Sitting ☐Sleep ☐Walking ☐Work

Prior Treatment ☐ Yes ☐Chiropractor ☐MD ☐Physio ☐RMT ☐Other______________ ☐ No

Examination: ☐ Yes ☐ No X-rays: ☐ Yes ☐ No Lab/Blood test: ☐ Yes ☐ No Other; ______________

Finding/Diagnosis: ______________ **Treatment:** ______________

Outcome: ______________________________

Expectations of consultation: ______________________________

Do we have your permission to consult with other health care practitioners at this clinic regarding your treatment ☐ Yes ☐ No

Family Doctor: ______________ **Tel. No.** (______)__________

Last medical / Check-up M________ Y________ **Findings:** ______________

Medical or Health Condition(s): ______________ ______________

______________ ______________

Medications: ______________ ______________ ______________

Supplements: ______________ ______________ ______________

Use the symbols below to show area(s) of pain or discomfort; include all affected areas

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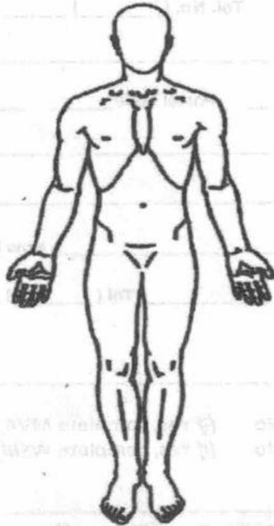
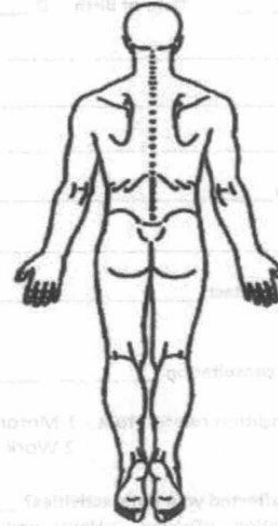
CHIROPRACTIC INTAKE FORM

Numbness: 00 Stiffness: ++ Pins & Needles: ** Burning: XX Dull Ache: -- Sharp Pain: ||





INTENSITY OF DISCOMFORT

0	1	2	3	4	5	6	7	8	9	10
None		Mild			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

% Sitting _______ % Standing _______ % Walking _______ % Other ____________________

Comment(s) ____

How did you find the clinic? ☐ **Ad/Promo** ☐ **Clinic Sign** ☐ **Event** ☐**Website** ☐ **Referral** ____________________

______________________________ Date D______M______Y______

Signature - Patient or Parent/Guardian