CHIROPRACTIC PATIENT

INTAKE & HISTORY

Katherine Sports & FAMILY CHIROPRACTIC

PATIENT INFORMATION

SURNAME

FIRST NAME

☐ MALE ☐ FEMALE DATE OF BIRTH

HOME ADDRESS

CONTACT TELEPHONE

EMAIL ADDRESS

PRIVATE HEALTH FUND

How many children do you have? ☐

OCCUPATION

IN CASE OF EMERGENCY CONTACT

NAME

RELATIONSHIP TO YOU

TELEPHONE

First visit to a Chiropractor? ☐ YES ☐ NO

PREVIOUS PRACTICE NAME

WHO MAY WE THANK FOR REFERRING YOU?

HOW CAN WE HELP YOU?

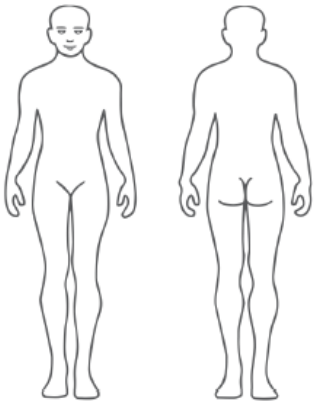
What brings you in today? ☐ SPINAL CHECK-UP ☐ SPECIFIC PROBLEM

If you are already experiencing a symptom, what is it? _____

When did it start/what caused it? _____

How bad is it? How intense are your symptoms? (0 = no symptom, 10 = intense) 10

Please circle areas (on diagram) where you have pain or other symptoms:



What does it feel like?

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- Other _____

IMPACT OF YOUR SYMPTOMS

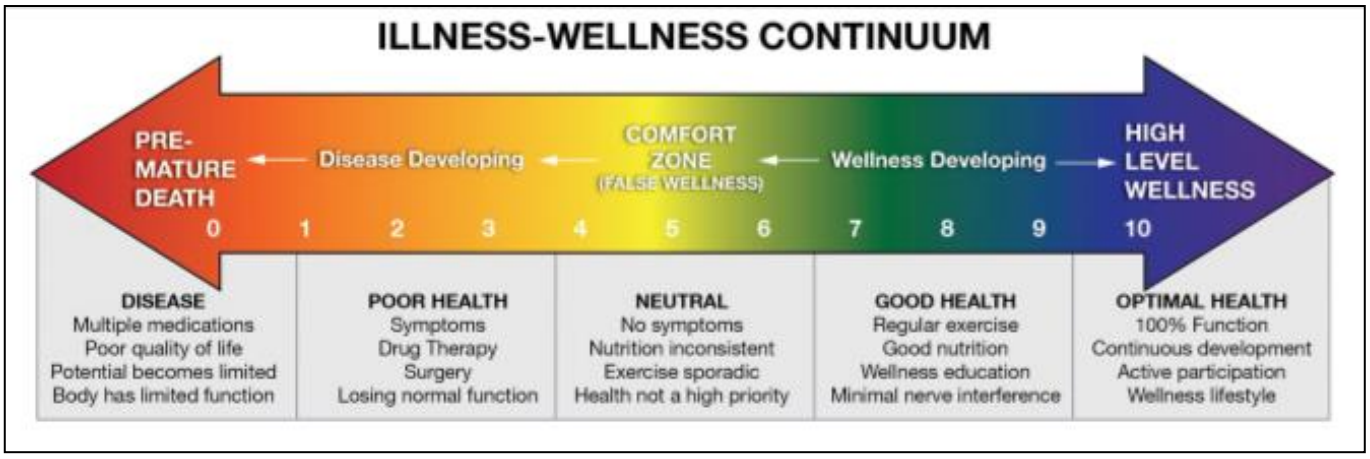
How is your symptom/condition interfering with your life?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

PATIENT WELLNESS ASSESSMENT

Please check each answer appropriately based on the last week.

	NEVER	RARELY	OCCASIONALLY	REGULARLY	CONSTANTLY
Presence of physical pain (neck/back ache, sore arms/legs)	☐	☐	☐	☐	☐
Feeling of tension/stiffness/lack of flexibility in your spine	☐	☐	☐	☐	☐
Feeling unable to perform everyday household activities	☐	☐	☐	☐	☐
Feeling of poor posture (sore neck/round shoulders)	☐	☐	☐	☐	☐
Incidence of physical restriction	☐	☐	☐	☐	☐
Incidence of muscle strain, spasm or cramping	☐	☐	☐	☐	☐
Incidence of pain with activity (catching restriction)	☐	☐	☐	☐	☐
Incidence of discomfort following activity (soreness)	☐	☐	☐	☐	☐
Incidence of dizziness or light headedness	☐	☐	☐	☐	☐
Incidence of accident/near accidents/falling/tripping	☐	☐	☐	☐	☐



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

SHORT TERM _____

LONG TERM _____

HEALTH & ILLNESS HISTORY

Please check any condition that you have or have had.

☐ AIDS/HIV	☐ Depression	☐ Knee/Ankle/Foot issues	☐ Thyroid issues
☐ Alcoholism	☐ Diabetes	☐ Multiple sclerosis	☐ TMJ issues
☐ Anxiety	☐ Digestive issues	☐ Neck pain	☐ Urinary issues
☐ Arthritis	☐ Elbow/Wrist/Hand issues	☐ Reproductive issues	☐ Osteoporosis
☐ Asthma/Allergies	☐ Headaches/Migraines	☐ Ringing in ears	Other
☐ Back pain	☐ Heart disease	☐ Scoliosis	_____
☐ Cardiovascular issues	☐ Hepatitis	☐ Shoulder issues	_____
☐ Cancer	☐ Hip issues	☐ Stroke	_____

ALLERGIES, MEDICATIONS & SUPPLIMENTS

Allergies *(list)*	Medications *(list)*	Supplements *(list)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Katherine Sports & FAMILY CHIROPRACTIC

CHIROPRACTIC CARE FOR THE WHOLE FAMILY

We are a family practice, meaning we are registered, trained and qualified to provide chiropractic services to people of all ages from babies, teenagers, adults and the elderly. If you suspect your child or loved one may have one of the below conditions, please check the box and talk to one of our doctors or staff about having them looked after.

☐ ADHD	☐ Allergies	☐ Asthma	☐ Bed wetting	☐ Birth trauma	☐ Breast feeding
☐ Clicky hips	☐ Colic	☐ Constipation	☐ Crawling	☐ Developmental	☐ Flat footed
☐ Flat-head	☐ Indigestion	☐ Irritability	☐ Knock knees	☐ Poor posture	☐ Reflux
☐ Restlessness	☐ Scoliosis	☐ Sleeping issues	☐ Tummy time	☐ Wry-neck	

INFORMED CONSENT TO CHIRPRACTIC CARE

I acknowledge, am aware of and understand the potential risks of manual therapies. I do not expect the Chiropractor to be able to anticipate or explain all of the risks and complications. I wish to rely on the Chiropractor to exercise his/her judgement during the course of the procedures which he/she feels, at the time, based upon the facts known, is in my best interests.

I have to the best of my knowledge provided the Chiropractor with a complete and accurate health history. I have had the opportunity to discuss with the Chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic adjustments and other chiropractic procedures wherever the Chiropractor determines necessary. By signing below, I agree to chiropractic care. I understand that I can withdraw my consent at any time.

PATIENT NAME: _____ **PATIENT SIGNATURE:** _____ **DATE:** _____

CHIROPRACTOR NAME: _____ **CHIROPRACTOR SIGNATURE:** _____ **DATE:** _____