Chiropractic Intake & History

Complete Care Chiropractic

PATIENT INFORMATION

All information contained in this questionnaire is strictly confidential

Full Name:		**Date of Birth:**
Address:		
Postal Address:		
Phone: (H)	(W)	(M)
Email Address:		
Occupation:		
Next of Kin Name:	**Contact Number:**	

Are you a member of a health fund that pays for Chiropractic Care? **Please ✓** ☐ Yes ☐ No ☐ Don't Know

If Yes, please provide name of health fund:

Do you have a concession card? Eg Health Care or Seniors card **Number:** **Expiry:**

HOW CAN WE HELP YOU?

What brings you in today?

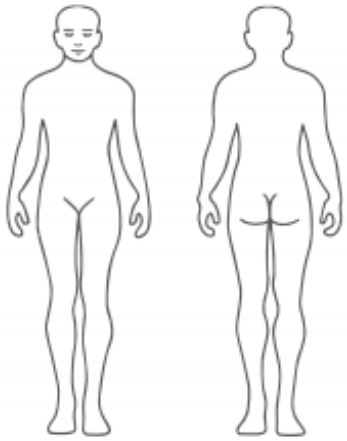
If you are already experiencing a symptom, what is it?

How bad is it? How intense are your symptoms?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

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

IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (check where appropriate

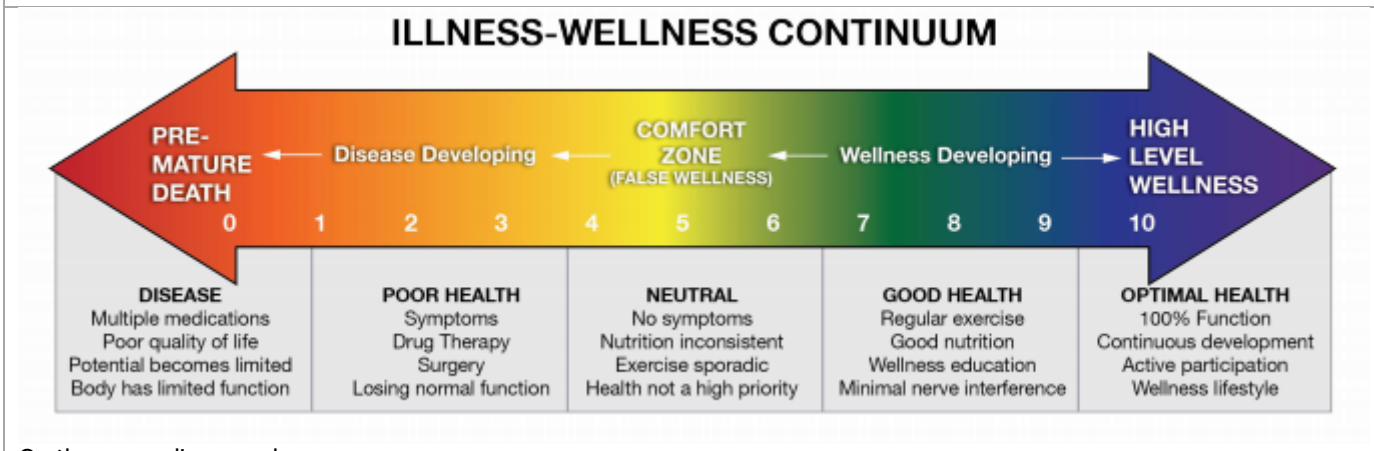
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other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

How committed are you to correcting this issue?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NOT COMMITTED — VERY COMMITTED

CLIENT WELLNESS ASSESSMENT



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?

Immediate:_____
Short Term: _____
Long Term:_____

CHILDREN AND PREGNANCY

How many children do you have?
_____

Children's ages?
_____

Children's health concerns?
_____
_____

Are you currently pregnant?
☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy?
_____

HEALTH AND ILLNESS HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/hand Issues
- ☐ Endocrine Issues
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

Are you currently taking any medications/vitamins/ supplements? If so, please list below.

Have you been in any motor vehicle accidents, motor bike accidents, or had any major falls? If so, please list below.

Have you had any surgery or been in hospital? If so, please list below.

Patient Consent: I have answered the questions on this form to the best of my knowledge and ability. I have had the opportunity to ask questions and obtain assistance if required. I consent to a professional and complete Chiropractic examination and to any radiographic or diagnostic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of consultation and cannot be deferred to a later date.

Patient Signature: _____ Date: _____