ChiroPath
SPINE & POSTURE CENTRE

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NEW PATIENT INTAKE FORM

Name		Date(MM/DD/YY)		Age		Gender	
Address							
City		Province		Postal Code			
Phone:	Home	Cell		Cell Phone Provider			
Email		Birthday*(MM/DD/YY)*					
Occupation		☐ Single ☐ Married ☐ Divorced ☐ Widowed					
Spouse's Name							
Names & Ages of Children							
Emergency Contact		Phone#					
Have you had previous chiropractic care?		☐ Yes ☐ No					
Who & When &Frequency?							
Medical doctor name		Medical doctor phone #					
How did you know about our office?							
Who can we thank for referral you?							

History of Health Concerns

Spinal Health Wellness Checkup?	☐ Yes ☐No
Reason For Visit *(Be Specific):*	
Have you suffered with this before or a similar condition in the past?	☐ Yes ☐No
Describe	
When was the last episode?	
How did the condition happen?	

HOW DOES YOUR CONDITION AFFECT YOUR LIFE?

How many days a week do you have the problem?			
It is worse in the:	☐ Morning ☐ Afternoon	☐ Evening ☐ Night	☐ Other
Overall, is your condition	☐ Staying Same	☐ Getting Better	☐ Getting Worse
How does it interfere with your activities?	☐ Annoyance ☐ Complete	☐ Tolerable	☐ Significant

Activities	No effect	Painful (can do)	Painful (limits)	Unable to perform
Carrying groceries				
Walking/Sit to Stand				
Static Sitting				
Climbing Stairs				
Pet Care				
Driving				
Computer Work				
Household chores				
Lifting Children				
Concentration/reading				
Yard work				
Dressing/bathing				
Sexual Activities				
Others:_____				

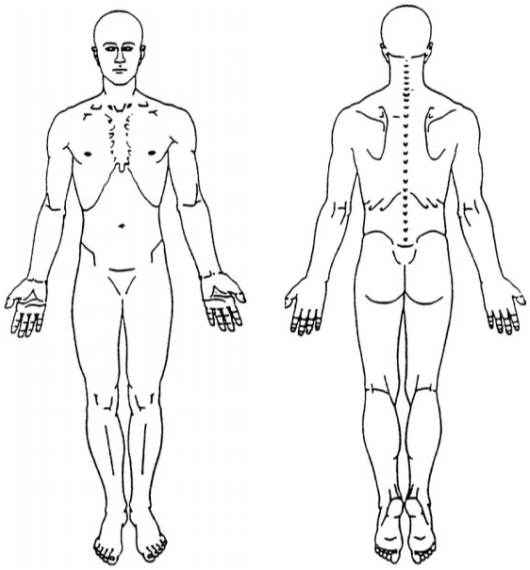
	Complete able to function ⟷ Totally unable to function
What is the AVERAGE level of the problem you experience in a typical day?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What is the LOWEST level of the problem you experience in a typical day?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What is the HIGHEST level of the problem you experience in a typical day?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
When you have the problem what % of the day is it present?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What makes your condition WORSE?		
☐ Sitting	☐ Straining at toilet	☐ Walking up hill
☐ Pulling	☐ Swimming	☐ In/out of bed
☐ Pushing	☐ Climbing ladder	☐ In/out of car
☐ Reclining	☐ Climbing stairs	☐ Anger
☐ Repetitive Movement	☐ Carrying	☐ Emotional upsetm
☐ Sneezing	☐ Lifting	☐ Stress
☐ Rising from chair	☐ Throwing	☐ Depression
☐ Coughing	☐ Turn head left	☐ Other
☐ Driving	☐ Turn head right	
☐ Standing	☐ Walking	

What makes your condition BETTER?		
☐ Resting	☐ Sleeping	☐ Aspirin
☐ Icing	☐ Exercising	☐ Hot showers
☐ Compression	☐ Reclining	☐ Chiropractic Care
☐ Elevation	☐ Bending	
☐ Heat	☐ Tylenol/Advil	

Please mark on the diaphragm with the following letters to describe your symptom:

R=Radiating **B=**Burning **D=**Dull **A=**Aching **S=**Sharp/Stabbing **T=**Tingling **N=**Numbness



Health History

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem

☐ Dizziness	☐ Numbness in Feet	☐ Scoliosis
☐ Headaches	☐ Low Back Pain	☐ Poor Posture
☐ Vertigo	☐ Hip Pain	☐ Asthma
☐ Seizures/Convulsions	☐ Leg Pains	☐ Liver Disease
☐ Ear Infections	☐ Knee Pain	☐ Lupus
☐ Nausea	☐ Shoulder Pain	☐ Fibromyalgia
☐ TMJ Pain	☐ Mid Back Pain	☐ Chest Pain
☐ Neck Pain	☐ Hand/Feet Pain	☐ Arm Pain
☐ Migraines	☐ Sciatica	☐ ADD/ADHD
☐ Anxiety	☐ Disc Herniation	☐ Nervousness
☐ Chronic Sinus	☐ IVF Stenosis	☐ Epilepsy
☐ Chronic Fatigue	☐ Irritable Bowl	☐ Arthritis
☐ Low Energy	☐ Menstrual Disorders	☐ Infertility
☐ Trouble Sleeping	☐ Heart Disorders	☐ Gastric Reflux
☐ Numbness in Arms	☐ Digestive Issues	☐ Other
☐ Numbness in Hands	☐ Bladder Problems	
☐ Numbness in Legs	☐ Thyroid Problems	

Check Any Condition You Have Now/Have Had:

☐ Stroke ☐ Scoliosis ☐ Heart Disease	☐ Cancer ☐ Diabetes ☐ Fracture	☐ Spinal Surgery ☐ Dislocation ☐ Seizures
All surgical operations & years		
List all non-prescription & prescription medications you are on, and the reason		
Were you ever in an auto accident? When?		
Have you ever been knocked unconscious?	☐ Yes ☐ No, If so, please describe	
Do you have any other medical condition other than that which you are now consulting us?	☐ Yes ☐ No	
Have you been told you have scoliosis, spinal arthritis or inherited spinal conditions?	☐ Yes ☐ No	
How would you rate your health right now?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	
Are you healthier than you were 5 years ago?	☐ Yes ☐ No	

History of Trauma

Work Posture	☐ Sit ☐ Stand ☐ Walk	☐ Do Desk Work ☐ Phone Work ☐ Drive	☐ Heavy lifting ☐ Do Mechanical Work
Have you, (even as a passaging, even if you do not think you were hurt), been involved in a vehicular collision, or near collision?			☐ Yes ☐ No
Please Describe			
Have you ever had a fall, even if you think you were not hurt?			☐ Yes ☐ No
Please Describe			

Physical trauma

☐ Physical fight ☐ Banged your head	☐ particular position sleeping ☐ particular position watching TV	☐ Sports Injury ☐ Concussion

Lifestyle History

☐ Exercise_____/week	☐ Drink caffeine_____/day	☐ Take supplements/herbs/vitamins
☐ Smoke_____/day	☐ Drink alcohol_____/day	☐ Other_____

Patient Name (please print) _____ Signature of patient (or legal guardian) _____ Date (MM/DD/YY) _____

RESET PRINT