PATIENT INTAKE FORM

PATIENT INFORMATION

Name:	Today's date (mm/dd/yy):	Your birthday (mm/dd/yy):	Age:
Address:	City:	Postal Code:	
Home Phone:	Work Phone:	Cell Phone:	
Occupation:	Employer:	Are you a full time student? ❒yes ❒no If yes, where?	
Alberta Health Care Number:	E-mail address:		
Is this a medical legal case? ❒ yes ❒ no	If yes, name of your lawyer		Is this a MVA or WCB? ❒ yes ❒ no
Whom may we thank for your referral to our clinic?	Have you received chiropractic care before? ❒ yes ❒ no	If yes, by whom?	Where?
Have you had imaging (ie. X-Ray, MRI, etc.) within the last 12 months? ❒ yes ❒ no	If yes, where?	What date?	

PATIENT HEALTH INFORMATION

What is your present health concern?		
When did this health concern start?	Who else have you seen for this concern?	Is the concern getting better, worse or unchanging?
Name of your family physician?	Name of any and all specialists that you are seeing, with reason you are seeing them:	
What health conditions have you sought care for in the last year?		

Medication – Please list all medication both prescription and over-the-counter taken in the last year:

1.	2.	3.	4.
Reason Prescribed:	Reason Prescribed:	Reason Prescribed:	Reason Prescribed:

Please list all Vitamins and supplements taken in the last year:

1.	2.	3.	4.
Reason Taken:	Reason Taken:	Reason Taken:	Reason Taken:

Please indicate your current level of/level of consumption of the following:

	None	*Light*	*Moderate*	*Heavy*		*None*	*Light*	*Moderate*	*Heavy*
Exercise	❒	❒	❒	❒	Tobacco	❒	❒	❒	❒
Sleep	❒	❒	❒	❒	Alcohol	❒	❒	❒	❒
Coffee	❒	❒	❒	❒	Junk Food	❒	❒	❒	❒
Tea	❒	❒	❒	❒	Stress	❒	❒	❒	❒

PAST HEALTH PROFILE

Please check any boxes that apply to your current condition and underline any conditions that you have previously experienced. Be as detailed as possible.

GENERAL:
❒Poor circulation/tissue swelling
❒Enlarged glands
❒Loss of weight
❒Hypoglycemia
❒Nervousness
❒Vision problems
❒Hearing problems
❒Frequent colds or flus

BODY SYSTEMS:
❒Frequent urination
❒Painful urination
❒Blood in urine
❒Kidney stones
❒Prostate problems
❒Anemia
❒Hypothyroid
❒Hyperthyroid
❒Gas/bloating
❒Constipation
❒Diarrhea
❒Colitis
❒Black/bloody stool
❒Hemorrhoids
❒Liver trouble
❒Gall bladder trouble
❒Eczema
❒Psoriasis
❒Varicose veins
❒Asthma
❒Shortness of breath
❒Heart problems

MUSCULOSKELETAL SYSTEM:
❒Low back pain/problems
❒Neck pain/problems
❒Mid back pain/problems
❒Shoulder pain/problems
❒Arm or Elbow pain/problems
❒Wrist or hand pain/problems
❒Hip pain/problems
❒Leg pain/problems
❒Knee or foot pain/problems
❒Pain/numbness in arms/legs
❒Painful tailbone
❒Pain between the shoulders
❒Scoliosis
❒Arthritis
❒Walking problems
❒Difficulty chewing / clicking jaw
❒Orthopedic Problem_____
❒Hernia
❒Whiplash
❒Bursitis – where? _____

NERVE SYSTEM:
❒Vertigo (Dizziness)
❒Loss of feeling
❒Fainting
❒Headaches
❒Tinnitus (ringing in ears)
❒Confusion
❒Depression
❒Insomnia (loss of sleep)
❒Low energy
❒Tremors/Twitching

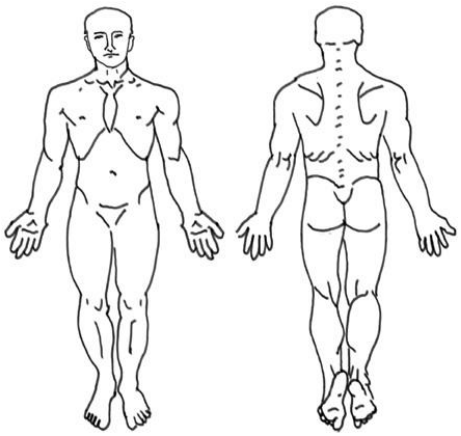
❒Hospitalization. Please Explain _____
❒Surgery. Please Explain _____
❒Accident. Please Explain _____

CHECK ANY OF THE FOLLOWING THAT A FAMILY MEMBER HAS EXPERIENCED

❒Heart Disease ❒High Blood Pressure ❒Arthritis ❒Neurological disorder
❒Cancer ❒Stroke ❒Diabetes ❒ Other:_____

ARE THERE ANY OTHER HEALTH CONDITIONS WE DID NOT ASK ABOUT THAT WOULD BE IMPORTANT TO KNOW? _____
_____

Please indicate your areas of pain on the above diagram.
A=Aching N=Numbness B=Burning
S=Stabbing P=Pins and Needles
Rate your pain level from 1 (mild) to 10 (severe): _____



FINANCIAL POLICY

Fees for professional services are payable when the service is rendered. Patients are ultimately responsible for their own fees for service. This applies to cases where WCB, third party payers (ie. insurance companies, etc.) disallow payment for your care regardless of the reason.

I understand and agree to the Shiloh Chiropractic Financial Policy.

_____
Patient / Parent / Guardian Signature