NEW PATIENT INTAKE FORM

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Today's Date: _____ /_____ /_____
DD MM YYYY

Personal Information

Patient Name: _____ Date of Birth: _____ /_____ /_____
First Middle Last *DD MM YYYY*

Age: _____ Gender: *Male / Female* Weight: _____ Height: _____ Referred by:_____

Address: _____ City/Prov: _____ Postal Code: _____

Phone: (H) _____ (Cell) _____ E-Mail _____

Emergency Contact: (name) _____ (relationship) _____ (Phone) _____

Occupation: _____ Family Doctor: _____ Specialist: _____

Primary Health Concern(s)

Reason for visit: _____ Is this a MVA or WSIB claim: Yes or No

Is this a new problem? _____ When did it begin? _____ Rate associated Pain: **0 1 2 3 4 5 6 7 8 9 10**
0 = no pain... 10 = worst pain

Describe Pain: *Sharp / Dull / Achy / Stabbing / Burning / Tingling / Throbbing / Spasm / Other:* _____

What relieves it? _____ What aggravates it? _____

Does it travel to other areas? _____ Other professionals seen for this? _____

Physical Stressors

Any significant falls, traumas, or injuries? _____ If yes, explain: _____

Any hospital visits? _____ If yes, explain: _____

List any surgeries, fractures bones, dislocations, and car accidents: _____

Exercise level: *Low* *Moderate* *High* *What do you do for exercise?* _____

Chemical Stressors

Do you use any of the following? List frequency if applicable:

Alcohol: _____ Cigarettes/Cigars: _____ Caffeine: _____

Antacids: _____ Laxatives: _____ Diet Soda: _____

Tylenol/Advil/Aspirin: _____ Recreational Drugs *(specify)* : _____

Are you exposed to any pollutants/ chemicals/aerosols, etc? Please List: _____

Mental/Emotional Stressors

How would you rate your overall health? **0 1 2 3 4 5 6 7 8 9 10** *(0 = Poor Health... 10 = Optimal Health)*

How would you rate your overall stress? **0 1 2 3 4 5 6 7 8 9 10** *(0 = No Stress... 10 = High Stress)*

How do you manage your stress? _____

Have you lost more than 20lbs in the past 90 days? _____

Initial: _____

Medical History

Medication Allergies: _____ Environmental Allergies: _____

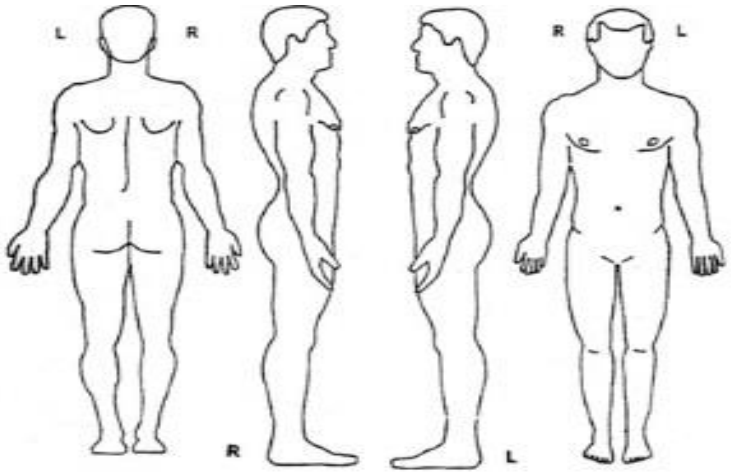
Do you have any difficulty or concerns with any of the following? Please check all applicable:

☐ Headaches	☐ Fainting or seizures	☐ High / Low blood pressure	☐ Diarrhea
☐ Shooting head pains	☐ Loss of balance	☐ Diabetes	☐ Painful Menstruation
☐ Sinus Trouble	☐ Ringing of ears/earaches	☐ Liver trouble	☐ Irregular menstruation
☐ Loss of smell/taste	☐ Hearing difficulty	☐ Anemia	☐ Miscarriage
☐ Hay fever / Allergies	☐ Eye / Vision problems	☐ Acid reflux or ulcers	☐ Arthritis
☐ Asthma	☐ Neck muscle spasms	☐ Abdominal pain	☐ Sacrum / Tailbone pain
☐ Cancer	☐ Tightness in shoulders	☐ Stomach trouble	☐ Painful joints
☐ Throat trouble	☐ Pain in shoulder & arms	☐ Indigestion	☐ Swollen Joints
☐ Infections	☐ Cold hands	☐ Nervousness	☐ Hip pain
☐ Thyroid trouble	☐ Pins and needles in hands / arms	☐ Irritability / moodiness	☐ Slipped or herniated disks
☐ Sleeping trouble	☐ Chest pain or pain in ribs	☐ Prostate trouble	☐ Pinched nerves
☐ Facial pain or palsy	☐ Shortness of breath	☐ Reproductive problems	☐ Pins and needles in legs / feet
☐ Loss of memory	☐ Carpal tunnel syndrome	☐ Bladder problems	☐ Swollen ankles
☐ Chronic fatigue	☐ Fibromyalgia	☐ Gall bladder problems	☐ Cold feet
☐ Depression/ Anxiety	☐ Heart palpitation / trouble	☐ Kidney trouble	☐ Numbness in legs
☐ Stress	☐ Upper back pain	☐ Groin pain	☐ Knee pain
☐ Dizziness / Vertigo	☐ Mid back / shoulder pain	☐ Constipation	☐ Pain in legs / feet
☐ Neck Pain	☐ Lower back pain	☐ Bowel Problems	☐ Jaw pain

→ Indicate with an "X" on the area's of the body that you are currently experiencing pain or discomfort.

→ Indicate with an "O" on the area's of the body that you are currently experiencing numbing or tingling.

→ Indicate with an "#" on the area's of the body that you are currently experiencing fatigue or weakness.



Family Health History

Please indicate any health issues within your immediate family:

Cancer / Stroke / Diabetes / High Blood Pressure / Arthritis / Dementia / Asthma / Heart Disease / Osteoporosis / High Cholesterol / Multiple Sclerosis/ Kidney Disease / Anemia / Tuberculosis / Mental Illness / Skin Disease

Medication History

Please list all medications you are currently taking including any supplements and vitamins and their frequency:

Medications / Vitamins / Supplements:	Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Initial: _____

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