Wellington Chiropractic

Chiropractic • Massage • Physiotherapy • Acupuncture

Chiropractic Intake Form

Personal Information

First Name: _____ Last Name: _____ Date_____

Date of Birth_____ (M/D/Y) Sex_____ (M/F)

Address: _____

Email address: _____

Home Phone_____ Work Phone_____ Cell phone _____

May we leave a message relating to your visit? _____ (Y/N)

If yes, at which number? Home [ ] Work [ ] Cellular [ ]

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Telephone Number: (Day) _____ (Evening) _____

Family Physician

Name_____

Address_____

_____

Phone_____

How did you hear about us?

Doctor _____ Friend _____ Walk-In_____

Ins Co.____ Family Member____ Other ___

Referral Source's Name _____

_____

****Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee****

This signed form and photocopies of this signed form will serve as authorization to Wellington Chiropractic to obtain/release medical information pertaining to myself from/to my family physician and to other Wellington Chiropractic practitioners. It also serves as an agreement to provide payment to Wellington Chiropractic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Patient Signature:_____ Date: _____

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Health Information

Have you had any previous chiropractic care? Yes ☐ No ☐

If yes, for what reason:_____

Please describe your chief complaint or area of concern:_____

_____

When did the problem begin?_____

Have you experienced this complaint in the past? Yes ☐ No ☐

If yes, how long ago? _____

Have you had previous treatment for this condition?

☐ Chiropractic ☐ Medical ☐ Other: _____

Did you have x-rays taken? Yes ☐ No ☐

What seems to make the condition better? _____

What seems to make the condition worse? _____

Are your symptoms: ☐ getting worse ☐ staying the same ☐ getting better

Is this a work related injury or an injury resulting from a car accident? Yes ☐ No ☐

Date of injury: _____

Please provide details of the injury: _____

Accidents/Fractures/Surgeries: _____

Medications (List all): _____

Any other information your treating practitioner should be aware of?

_____

Are you gaining or losing weight without trying? _____

Exercise: Yes ☐ No☐ How many times per week? _____

Do you smoke? Yes ☐ No ☐ How many per day? _____ For how long? _____

Do you consume alcohol? Yes ☐ No ☐ How many drinks per week? _____

How many hours of sleep do you get each night? _____

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Pain Diagram

Please use the following symbols to indicate the type and location of the symptoms you are experiencing by marking them on the diagram below.

//// Sharp/Stabbing

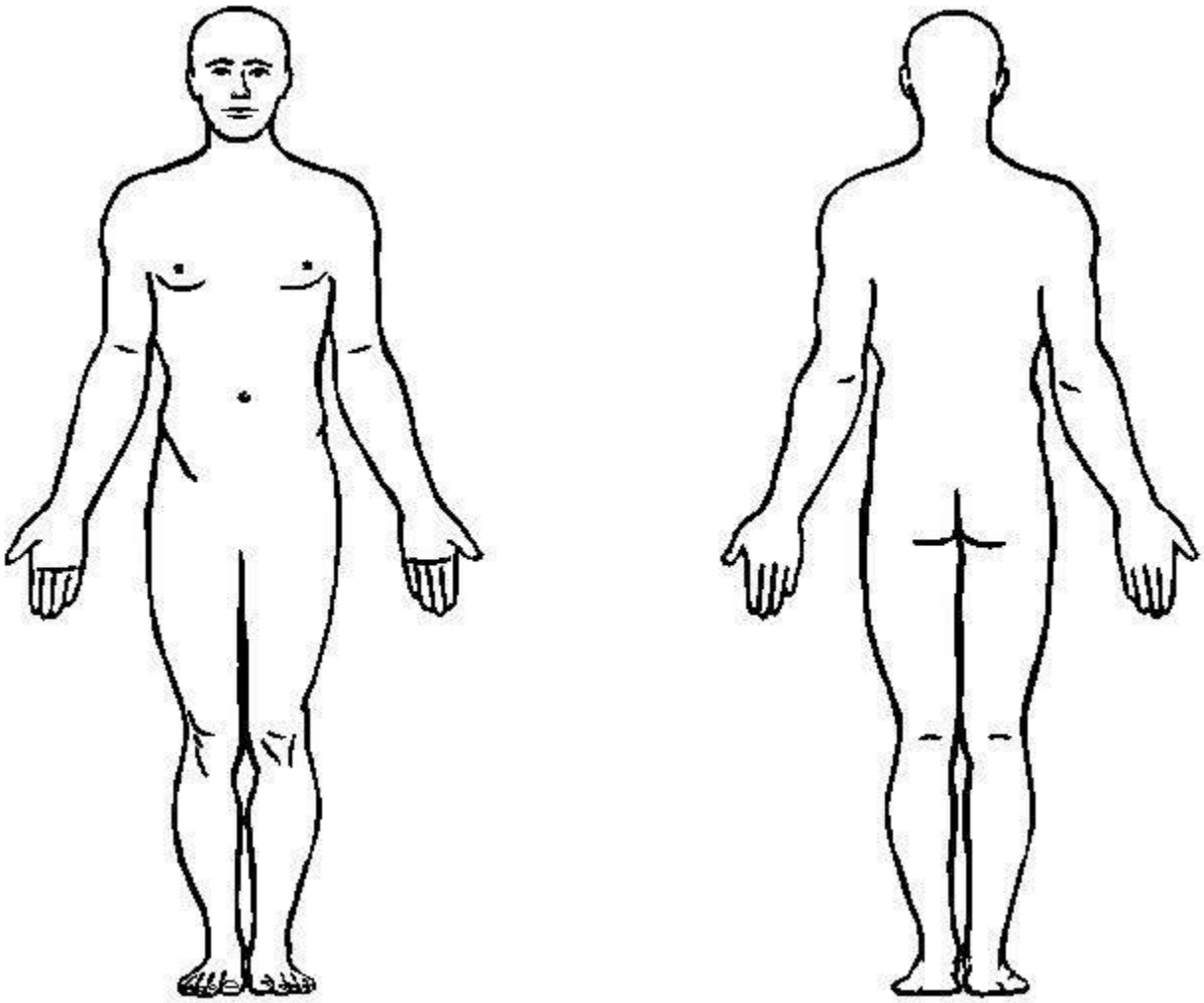
++++ Dull/Aching

2222 Stiff/Tight

xxxxBurning

==== Numbness

oooo Pins & Needles



Please circle your current pain level

No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

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Please complete by checking all the boxes that apply to you

Heart/Circulatory Conditions ☐

Dizziness/Fainting ☐

Muscle/Joints-Pain/Tension

Neck ☐

Shoulders ☐

Elbows ☐

Back (upper, mid, lower) ☐

Hips ☐

Knees ☐

Other ☐ _____

Rheumatoid Arthritis ☐

HIV/AIDS ☐

Skin Conditions/Bruising ☐

Digestive/Urogenital Conditions ☐

Breathing/Respiratory Conditions ☐

Diabetes ☐

Cancer ☐

For Women: Pregnant? ☐

Number of weeks_____

Due Date_____

Injury Affecting Sleep Yes ☐ No ☐

Blood Pressure High ☐ Low ☐

Please indicate if you or your immediate family members have/had any of the following conditions. If so, please indicate your relation next to the condition.

☐ Cancer_____

☐ Heart Disease _____

☐ Stroke _____

☐ Atherosclerosis _____

☐ Diabetes _____

☐ High Cholesterol _____

☐ Hypertension _____

☐ Arthritis/ Rheumatism _____

☐ Other: _____

I have correctly stated all conditions that I am Aware of and this information is true and accurate. I will inform Wellington Chiropractic of any changes to my health status.

**Patient's Name:_____

Date:_____