Chiromedics
HEALTH CENTRE

3621 Highway 7 East, Unit 123
Markham, Ontario
L3R 0G6
Phone: (905) 489-1928 ■ Fax: (905)489-1937
www.chiromedics.ca

New Patient Intake Form

Patient Information

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. _____
First Name Surname

Address: _____
Street City/Town Postal code

Age: _____ Date of Birth: _____ Marital Status: _____
YYYY / MM / DD

Phone #: Home( ) _____ Work: ( ) _____ Cell: ( ) _____

Can we leave a message? If yes, please specify at which location ☐ Home ☐ Work ☐ Cell

Occupation: _____ Employer's Name: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Physicians Name: _____ Phone #: ( ) _____

Address: _____
Street City/Town Postal code

Extended Health Care Carrier (if Applicable): _____

How did you hear about this office? _____

Were you referred to this office? ☐ Yes ☐ No If Yes, by whom? _____

Health Information

Have you had previous: ☐ Chiropractic Care ☐ Physiotherapy ☐ Acupuncture ☐ Massage Therapy

If yes, please specify the reason for care: _____

Please specify the reason for today's visit: _____

Have you had this pain before? ☐ Yes ☐ No If, yes when: _____

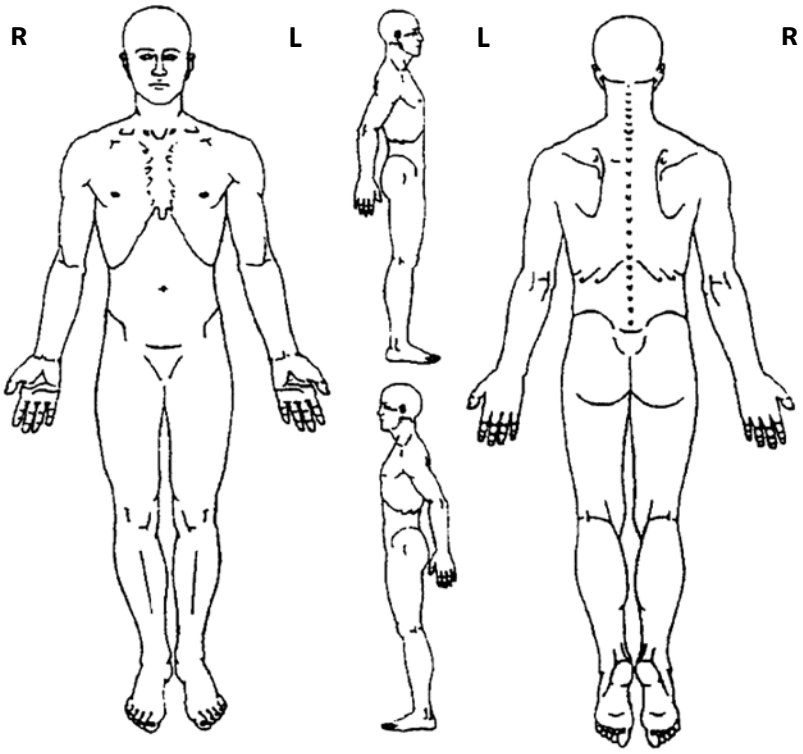
How are the symptoms changing? ☐ Gotten worse ☐ Stayed the same ☐ Gotten better

Is your Injury a result of: ☐ Motor Vehicle Accident ☐ Work Related ☐ Sport Related

If Other Please Specify: _____

Instructions: Please mark the area of injury or discomfort on the adjacent diagram, using the appropriate symbols:

Numbness	– – – – – – – – – – – –
Pins & Needles	○○○○○○○○○○
Aching	+ + + + + + + + + + + +
Burning	XXXXXXXXXXXXXXXXX
Stabbing	//////////////////////



On a scale of 0 to 10, please circle the average intensity of your symptoms:

No pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst possible pain**

Review of Systems – Please check in the box below any condition you have had or presently have:

Musculoskeletal System
- ☐ Neck problems
- ☐ Upper back problems
- ☐ Shoulder problems
- ☐ Elbow/wrist problems
- ☐ Low back problems
- ☐ Knee problems
- ☐ Ankle/knee problems
- ☐ Arthritis

Nervous System
- ☐ Numbness or tingling
- ☐ Loss of feeling
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Confusion
- ☐ Depression
- ☐ Forgetfulness
- ☐ Seizures/Epilepsy

Genito-Urinary System
- ☐ Painful urination
- ☐ Excessive urine
- ☐ Scanty urine
- ☐ Discolored urine
- ☐ Incontinence/retention

Cardio-vascular-respiratory
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm/blood
- ☐ Lung problems
- ☐ Varicose veins/phlebitis
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Pacemaker or similar device

Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Abdominal pain
- ☐ Excessive thirst
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Incontinence
- ☐ Bloody/black stool
- ☐ Liver/gallbladder trouble
- ☐ Weight trouble

Ear, Eyes, Nose and Throat
- ☐ Eye problems
- ☐ Vision problems
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Allergies
- ☐ Hoarseness

Female
- ☐ Premenstrual syndrome
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Pregnancy
- ☐ Breast pain and/or lumps

Infections
- ☐ Fever
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Medications

Are you currently taking any medications (prescription or over the counter)? If yes, please note:

1- Medication _____ Dosage _____
2- Medication _____ Dosage _____
3- Medication _____ Dosage _____
4- Medication _____ Dosage _____
5- Medication _____ Dosage _____

Family History

Please check if any one of your family members have or have had any of the following, and if so how are you related?

- ☐ Cancer _____ Mother_____ Father_____ Sibling_____ Other (specify) _____
- ☐ Heart Disease _____ Mother_____ Father_____ Sibling_____ Other (specify)_____
- ☐ Stroke _____ Mother_____ Father_____ Sibling_____ Other (specify) _____
- ☐ Diabetes _____ Mother_____ Father_____ Sibling_____ Other (specify) _____
- ☐ High Cholesterol _____ Mother_____ Father_____ Sibling_____ Other (specify) _____
- ☐ Hypertension _____ Mother_____ Father_____ Sibling_____ Other (specify) _____
- ☐ Other, Please specify _____

Social History

Do you smoke? ☐Yes ☐No If yes, how many packs/day? _____ For how long? _____

Do you consume alcohol? ☐Yes ☐No If yes, how many drinks/week?_____

Do you exercise? ☐Yes ☐No If yes, how many times/week? _____

Terms and Policies

We require **24 hours notice**, if a patient/client is unable to keep a scheduled office appointment. This allows the clinic to accommodate other patients/clients. All patients/clients who cancel appointments with fewer than 24 hours notice will be subject to the full service fee.

I have read and understand this policy.

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Chiromedics Health Centre of any changes to my status.

Print Name _____

Sign Name _____

Today's Date _____