body works

CHIROPRACTIC INTAKE FORM

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All infomation is strickly confidential under the Provider-Patient relationship and nothing will be released unless instructed to do so by the patient.

PATIENT INFORMATION

Name:_____ Date : _____

Date of birth: _____ Occupation: _____

Address:_____

City:_____ Province:_____ Postal Code:_____

Home:_____

Work: _____

Cell:_____

Emergency Contact:_____

Contact Number:_____

Relationship:_____

Email:_____

Medical Doctor:_____ PEI Health Card No._____

INSURANCE INFORMATION

We can bill most private health insurance plans directly.

If you do NOT have insurance, please tick this box and proceed to the next section.

Insurance Provider: _____ Policy/Group/Plan number: _____

ID number: _____ *If you are not the policy holder, complete below*:

First & last name: _____ Date of Birth: _____

Relationship to policy holder: Spouse /Child /Other: _____

MEDICAL HISTORY/INFORMATION

Is this complaint a result of motor vehicle collision? YES / NO

Is this complaint a result of a work place injury? YES / NO

If yes do you have WCB number? _____

Prior Chiropractic Care? Yes / No Treatment Provider: _____

Date of last Visit: _____ Results: Excellent Good Fair Poor

Other care? Chiropractic: Current / Previous Massage Therapy: Current / Previous

Other:_____

What is the complaint you are seeking treatment for? _____

_____

How/when did the problem begin? _____

What type of pain have you been experiencing? **Circle** all that apply: Sharp Stab Twinge

Dull Ache Throb Burn Other: _____

Do you exercise? If yes, please describe: _____

_____

List any medications/vitamins you are currently taking:

_____

_____

List any fractures/loss of consciousness/major traumas/falls or accidents:

_____

_____

Have you ever been hospitalized or had any surgeries/operations? If yes, please list with dates:

_____

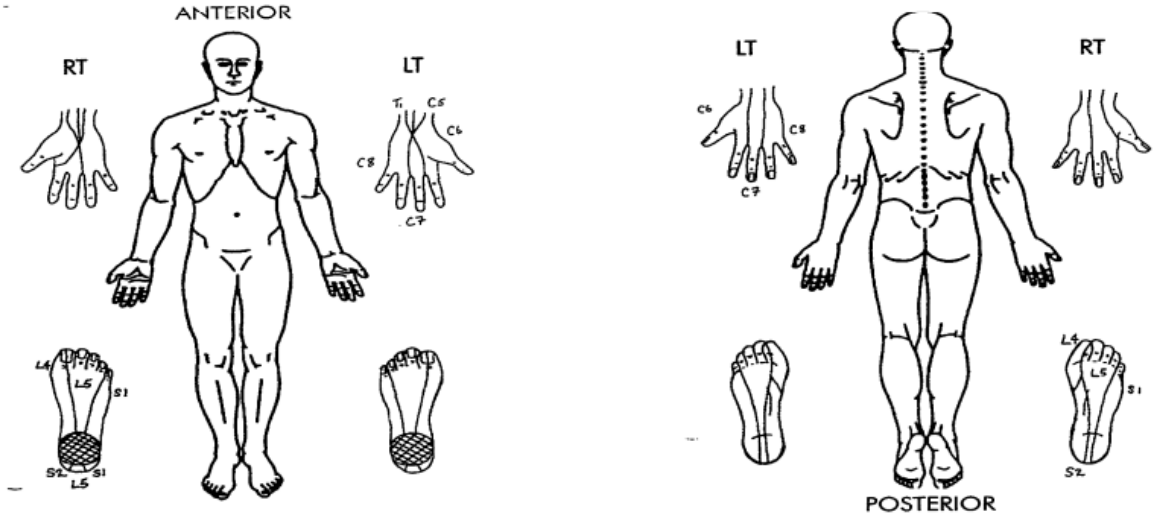
_____

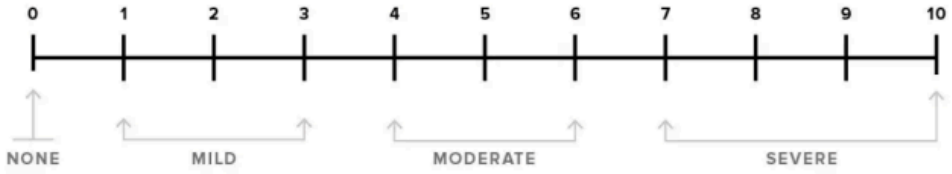
Do you: Smoke cigarettes? Yes No Occasionally

Consume alcohol? Yes No Occasionally

Consume cannabis? Yes No Occasionally

Please circle area(s) of concern:





Using the numeric pain scale above, please indicate on a scale of 1 to 10…

- The current level of pain you are experiencing: _____ out of 10
- The worst level of pain you have experienced over the last 14 days: _____ out of 10
- The lowest level of pain you have experienced over the last 14 days: _____ out of 10
- The average level of pain you have experienced over the last 14 days: _____ out of 10

Family Health Conditions (tick all that apply to your immediate family members):

- ☐ Asthma
- ☐ Birth defects (such as spina bifida or a cleft lip)
- ☐ High blood pressure (hypertension) or high cholesterol
- ☐ Genetic conditions (such as cystic fibrosis or haemophilia)
- ☐ High blood pressure (hypertension) or high cholesterol
- ☐ Heart disease or sudden heart attack
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Mental illness
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Personal Health Conditions (tick all that apply to you):

- ☐ Aneurysm
- ☐ Diabetes
- ☐ Heart conditions
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Fatigue
- ☐ Pleurisy
- ☐ Polio
- ☐ Stroke
- ☐ Asthma
- ☐ Epilepsy
- ☐ Other: _____
- ☐ Cancer
- ☐ Difficulty sleeping
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Allergies: _____
- ☐ Respiratory conditions
- ☐ Anxiety/Depression
- ☐ Sinus conditions
- ☐ Hepatitis/HIV/V.D.