Peak Performance Chiropractic Clinic

Patient Intake Form File # _____

Patient Information

Mr. Mrs. Ms. Dr. (Circle One) Sex M ____ F ____ Date _____

Name _____ DOB (dd/mm/yyyy) _____ / _____ / _____

Home Address _____ Town _____

PO Box _____ 911# _____ Apt # _____ Postal Code _____

Telephone (home) _____ (work) _____

Other Telephone _____ Email _____

Emergency Contact Name _____ Telephone _____

Health Card Number (OHIP): _____

Occupation _____

Employer _____ Town _____

PLEASE ADVISE US OF ANY CHANGES TO THE ABOVE INFORMATION

Please notify reception if this visit is due to a Motor Vehicle Collision or WSIB injury.

How did you hear about our clinic? (Circle one) Yellow Pages Front Sign The Post

Mildmay Town Crier Walkerton Herald Times Walk-In Medical Doctor Internet

Other _____ Referred by a friend (name) _____

Have you had x-rays taken in the past five years? Y / N When? _____

At which facility? _____

What body part was x-rayed? _____

Current Medical Doctor

Name _____ Telephone _____

Clinic Name _____ Town _____

Prior Chiropractic Care

Name _____ Town _____

Results: Excellent Good Fair Poor Last Visit _____

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Complaint History

Name _____

Please describe your current complaint _____

_____

When did it occur? _____ How did it occur? _____

List the following (and when they occurred):

1. Major surgeries _____
2. Serious illnesses/hospitalizations _____
3. Significant injuries (broken bones, sprains, falls)_____
4. Car/vehicle accidents _____
5. Other major health problems _____

When was your last medical appointment or physical?

_____

Please list any medications, vitamins, or supplements that you are currently taking: _____

_____

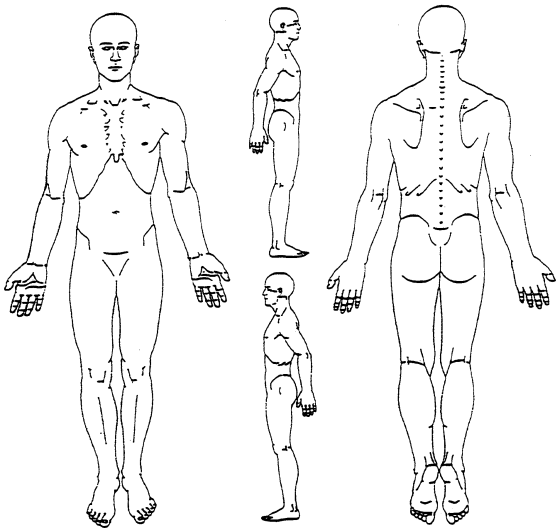
_____

Have you ever smoked in the past? Y / N Are you currently a smoker? Y / N Amount _____

Have you ever had a substance abuse problem (e.g. alcohol, drugs)? Y / N

_____

MARK THE AREAS OF THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS.
Use the appropriate symbols. Include all affected areas.



Numbness: + + +

Pins & Needles: o o o

Burning: x x x

Stabbing: / / / /

Stiff, Tight: # # #

Dull, Aching: A A A

Pressure: > > >

_____

RATE THE SEVERITY OF YOUR PAIN BY CIRCLING A NUMBER BELOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Severe Pain

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Family History

Name _____

Have your grandparents, parents, siblings, aunts, uncles or cousins, ever been diagnosed with any of the following? *Please indicate the relationship.*

___ High blood pressure
___ Heart disease
___ Stroke
___ Diabetes (Type I or Type II)
___ Thyroid/hormonal problems
___ Breathing or lung problems
___ Rheumatoid Arthritis
___ Osteoarthritis
___ Neurological problems
___ Cancer
___ Kidney disease
___ Other (specify) _____

Patient Health History

**Please check anything that is causing you problems right now.*
Please **circle anything that has been a problem in the past.*

General
___ Persistent fatigue
___ Nervousness
___ Blackouts
___ Loss of consciousness
___ Headache
___ Fever
___ Sweats
___ Fainting
___ Dizziness
___ Loss of sleep/insomnia
___ Numbness
___ Tingling
___ Lack of energy
___ Skin problems
___ Rashes
___ Allergies (please list below)

Muscles/Joints
___ Back pain
___ Neck pain
___ Jaw pain L / R
___ Shoulder pain L / R
___ Elbow pain L / R
___ Wrist pain L / R
___ Hand pain L / R
___ Foot pain L / R
___ Ankle pain L / R
___ Knee pain L / R
___ Hip pain L / R
___ Painful tailbone
___ Arthritis
___ Swollen joints
___ Weakness

Respiration
___ Chronic cough
___ Painful breathing
___ Asthma
___ Difficulty breathing
___ Spitting up blood
___ Chest pain

Digestion
___ Diarrhea
___ Constipation
___ Vomiting
___ Nausea
___ Indigestion
___ Poor appetite
___ Excessive hunger
___ Ulcer
___ Liver problems
___ Jaundice
___ Belching or gas
___ Pain over stomach
___ Painful bowel movement
___ Gallbladder problems

Cardiovascular
___ High blood pressure
___ Heart or blood disease
___ Hardening of arteries
___ Bleeding disorder
___ Bruise easily
___ Heat/cold intolerance
___ Swelling of ankles
___ Angina
___ Stroke
___ Varicose veins
___ Poor circulation
___ Heart pain

Menstruation (women only)
___ Breast lump/pain
___ Severe menstrual cramps
___ Hot flashes
___ Irregular cycle

Genitourinary
___ Kidney infection
___ Bladder infection
___ Prostate trouble
___ Bedwetting
___ Blood in urine
___ Frequent urination
___ Difficulty urinating
___ Painful urination

Eyes, Ears, Nose, Throat
___ Eye/vision problems
___ Double vision
___ Blurred vision
___ Deafness
___ Earache
___ Sinus infection
___ Enlarged glands
___ Frequent colds
___ Speech difficulty
___ Difficulty swallowing

Other
___ Seizures/epilepsy
___ Diabetes
___ High cholesterol
___ Multiple Sclerosis
___ Cerebral Palsy
___ HIV/AIDS
___ Cancer
___ Other _____

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Concerns Name _____

Do you have any concerns regarding the therapy that you would like us to address before we begin treatment?

_____

_____

_____

Females Only

Date of last menstrual period? _____ Are you currently pregnant? Y / N

Have you ever taken birth control pills? (please name) _____

Are you currently taking birth control pills? (please name) _____

How many children do you have? _____

How many pregnancies have you had? _____

_____

Sharing information

I hereby authorize practitioners at Peak Performance Chiropractic Clinic to release or obtain any health information from my other healthcare providers as may be required for the management of my case. I understand that my personal information will be used only for the purpose it was collected.

Access to medical reports

I give practitioners at Peak Performance Chiropractic Clinic permission to review my medical reports and imaging from GBIN Medical Imaging Portal.

Payment policy

I understand that I am responsible for the fee if I miss an appointment or fail to give 24 hours cancellation notice. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Patient Signature: _____

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