WestHills Chiropractic & Massage

129 Stewart Green SW. Calgary, AB. T3H 3C8
www.WestHillsChiropractic.ca

(403) 217-4480

Date: ______________________

Name: ____

Address: ____

City: _______________________ Postal Code: _________________

Phone: Home: ______________ Work: _______________________

Cell: ______________ Other: _______________________

Email: ____

Date of Birth: ______________________ Gender: Female / Male

Alberta Health Care Number: ___________________________________

Occupation: ____

Referred to our office by; (Friend, Location, MD, etc) _________________

Do you have any third party insurance - (Blue Cross, Sun Life, Great West Life, etc)?

Insurance Company: _______________________________

Name on Policy: _______________________________

Policy Number: _______________________________

ID Number: _______________________________

Emergency Contact:

Name: ___________________________ Phone Number: ______________

WestHills Chiropractic & Massage
129 Stewart Green SW. Calgary, AB. T3H 3C8
www.WestHillsChiropractic.ca
(403) 217-4480

Chiropractic Intake Form

Patient Name: ____ Date: ______________

Please describe the location, length of time, and severity of your concern?

____

____

____

Is this a result of a Motor Vehicle Accident? YES NO

Is this a Workers Compensation Injury? YES NO

Have you had Chiropractic treatment before: YES NO

How was your experience: Positive Neutral Negative

Name of Previous Chiropractor: _______________________Date Seen_________________

Name of Medical Doctor: _____________________________Date Seen ________________

Date of Last Spinal X-Rays: ___________________________Taken Where______________

Have you ever been involved in any major trauma? (Car Accident, Sports Injuries, etc)

____

____

Have you ever had any spinal surgery? YES NO

Details: ____

Additional information about your health that you feel we should know? ______________

____

Health History:

Patient Name: ____ Date: _____________

Please mark beside all the conditions that have affected you, or your family:

Personal History	Condition	Family History
	Headaches	
	Neck Pain/Problems	
	Shoulder Pain/Problems	
	Mid Back Pain/Problems	
	Low Back Pain/Problems	
	Arm / Hand Problems (Numb, Tingling, etc)	
	Leg / Foot Problems (Numb, Tingling, etc)	
	Disc Problems (Degeneration, Herniation, Bulge)	
	Osteoporosis	
	Diabetes	
	Cancer	
	High Blood Pressure	
	Low Blood Pressure	
	Stroke	
	Heart Attack	
	Chest Pain	
	Respiratory Problems	
	Asthma	
	Prostate Problems	
	Frequent Colds	
	Nose Bleeds	
	Sinus Trouble	
	Urination Difficulty	
	Premenstrual Tension	
	Physical Abuse	

Are you a smoker: YES NO If Yes, How much a day? _________________

Previous Smoker? If Yes, Quit When? _________________