WESTHILLS CHIROPRACTIC
MASSAGE AND SPORTS THERAPY
MOVE BETTER FEEL BETTER LIVE BETTER

CLINIC INTAKE FORM

Date: _____

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: Home: _____ Cell: _____

Email: _____
(email address is used for appointment reminders, receipts)

Date of Birth (mm/dd/year) _____ Age: _____

Biological Sex: Female / Male / Non-Specified

Alberta Health Care Number: _____

Occupation: _____

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

Do you have any third-party insurance (Blue Cross, Sunlife etc): YES NO

Emergency Contact Name: _____Phone Number: _____

PATIENT SIGNATURE: _____

WESTHIILS TOWNE CENTER
129 STEWART GREEN SW
CALGARY, AB. T3H 3C8
(403) 217-4480
WWW.WESTHILLSCHIROPRACTIC.CA

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CHIROPRACTIC INTAKE FORM

Patient Name: _____ Date: _____

Reason for Appointment: _____

_____

When did your condition begin: _____

Have you had similar problems previously: _____

Have you had X-ray, MRI or other imagine done?

If Yes: What Test: _____ When: _____

Is this a Work Related Injury: Yes / No Has it been reported: Yes / No

Is this a Motor Vehicle Accident: Yes / No Date of Accident: _____

Stress Level: (none) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (high)

Activities Level (none) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (high)

Have you had Chiropractic treatment before: Yes No

How was your experience: Positive Neutral Negative

Name of Previous Chiropractor _____Date Seen: _____

Name of Family Doctor Name: _____

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Health History:

Patient Name: _____ Date: _____

List all previous surgeries, illness and injuries (including MVA's)	List all medications, (over the counter and prescriptions)

Additional information about your health that you feel we should know:

_____

Health History:

Please check the appropriate box for any of the following symptoms which you have now or have had previously

O = Occasional F = Frequent C = Constant

O	F	C	Nervous System
☐	☐	☐	numbness / tingling
☐	☐	☐	chronic pain
☐	☐	☐	herpes / shingles
☐	☐	☐	fatigue
☐	☐	☐	sleep disorders

O	F	C	Digestive
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	gas / bloating
☐	☐	☐	diverticulitis
☐	☐	☐	Irritable bowel syndrome

O	F	C	Musculoskeletal
☐	☐	☐	Bone or joint disease
☐	☐	☐	tendonitis
☐	☐	☐	bursitis
☐	☐	☐	broken / fractured bones
☐	☐	☐	arthritis
☐	☐	☐	sprains / strains
☐	☐	☐	low back, hip, leg pain
☐	☐	☐	neck, shoulder, arm pain
☐	☐	☐	spasms / cramps
☐	☐	☐	jaw pain / TMJ
☐	☐	☐	flat feet / high arches

O	F	C	Circulatory
☐	☐	☐	heart condition
☐	☐	☐	varicose veins
☐	☐	☐	blood clots
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	lymphedema

O	F	C	Skin
☐	☐	☐	dryness
☐	☐	☐	bruises easily
☐	☐	☐	allergies
☐	☐	☐	rashes
☐	☐	☐	athletes foot
☐	☐	☐	warts

O	F	C	Respiratory
☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	asthma
☐	☐	☐	allergies
☐	☐	☐	ear aches

O	F	C	Genito-Urinary
☐	☐	☐	pregnant
☐	☐	☐	PMS
☐	☐	☐	menopause
☐	☐	☐	frequent urination
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble

O	F	C	Other
☐	☐	☐	cancer / tumors
☐	☐	☐	diabetes
☐	☐	☐	mental health condition
☐	☐	☐	poor nutrition
☐	☐	☐	drug/alcohol consumption
☐	☐	☐	nicotine
☐	☐	☐	caffeine

Family History

Diabetes ☐
Arthritis ☐
Heart Disease. ☐
Stroke ☐