ASPIRE PHYSIOTHERAPY

Chiropractic Intake Form

Date: _____

PATIENT INFORMATION

Name _____ Cell Phone # _____

Email _____ Home Phone # _____

Date Of Birth _____ AHC # _____

Address _____ City _____

Family Doctor _____ Postal Code _____

Emergency Contact Name _____ Phone # _____

Referral Source:

☐ Google ☐ Doctor ☐ Social Media ☐ Family/Friend

Whom can we thank for this referral? _____

*Emails will be used for receipts, appointment reminders, and clinic marketing.

WCB

Is this injury a WCB claim? ☐ Yes ☐ No

Claim #_____ Date of accident _____

MVA

Is this injury from a Motor Vehicle Accident? ☐ Yes ☐ No

Insurance Company _____ Insurance Phone # _____

Fax # _____ Date of Accident _____

Adjuster Name _____ Adjuster Email _____

Claim # _____ Policy # _____

I understand that if my MVA claim is NOT accepted, I am responsible for any fees related to my treatments (**Initial**): _____

HEALTH & LIFESTYLE INFORMATION

Please check all answers and fill in the blanks where appropriate.

Reason(s) for appointment: _____

When did your condition begin? _____

Have you ever had similar problems? ☐ Yes ☐ No
Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No
Which tests, when? _____

_____

Can you perform daily home activities?	☐ Yes	☐ Yes, with help	☐ Not at all
Can you perform your daily work activities?	☐ All activities	☐ Only some	☐ Not at all
Describe your stress level ☐ None	☐ Mild	☐ Moderate	☐ High
Do you exercise?	☐ Daily	☐ Occasionally	☐ Not at all

What kinds of exercise do you do? _____

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

_____

_____

HEALTH HISTORY

Circle any conditions that are **presently** causing you a problem.

Underline those that have caused you problems in the **past**.

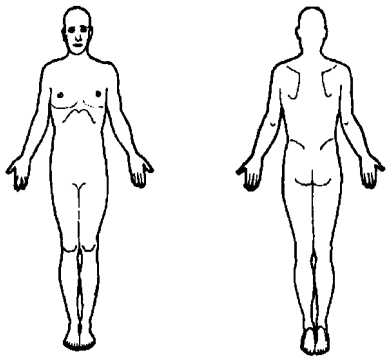
GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble

Weight loss Weight gain	Asthma	Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hand or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:

Have you ever been diagnosed or told you have any of the following?
Circle the correct response.

1. High blood pressure ---------- Yes No
2. Hardening of the arteries (arteriosclerosis) ---------- Yes No
3. Diabetes ---------- Yes No
4. Tuberculosis ---------- Yes No
5. Cancer ---------- Yes No
   Where? _____
6. Heart or blood diseases ---------- Yes No
7. Bone spurs on the neck bones (cervical sprain) ---------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) ---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From _____ to _____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision) ---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
14. Slurred speech or other speech problems ---------- Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------- Yes No
19. Collapse without loss of consciousness ---------- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

POLICIES & CONSENT

Cancellation Policy:

We are here to provide you with the very best care and attention. Your treatment time is reserved just for you. In our commitment to provide an outstanding experience to all our patients, and out of consideration for our practitioner's time, we will be enforcing a cancellation and no-show policy. **A minimum of 24 hours is required for cancellations, or a $50.00 cancellation fee will be charged to your account.** As a courtesy to our patients, if you arrive late, your appointment will be shortened to the remainder of your original scheduled appointment.

By signing this, I hereby:

- **authorize the release of all necessary information to my primary care provider and/or referring physician.**
- **understand the cancellation policy and acknowledge the potential charges for late cancellations or no-shows.**
- **have read this form and agree to all consent regarding chiropractic evaluation and treatment.**

Patient/ Legal Representative Signature: _____

Name: _____ Dated: _____

Chiropractor: _____ Dated: _____