Clayton Heights
CHIROPRACTIC

Patient Intake Form

We are pleased that you have chosen to consult us regarding your health. Please complete the following questionnaire of your basic personal information. If you see more than one practitioner in our clinic, this information will be shared. Thank you!

Name: _____ Date of Birth:_____ Age: ____
Address:_____
City: _____ Province: _____ Postal Code: _____
Home Telephone:_____ Cell:_____ Work:_____
Email:_____ Please circle if you prefer **email** or **phone reminders**?
Care Card Number: _____ Number of Children:_____
Occupation:_____ Family Doctor:_____
Primary Extended Insurance Provider for direct billing:_____
Policy Number:_____ Member ID:_____

How did you become aware of Clayton Heights Chiropractic?

- ☐ I was a patient at practitioner's previous location
- ☐ Another patient recommended: (Patient Name) _____
- ☐ Referred by another practitioner: (Practitioner's Name)_____
- ☐ Internet/Google search
- ☐ Saw Office Signs
- ☐ Social Media (Facebook, Twitter, Blog, etc):_____
- ☐ Other: (Please specify)_____

Health History:

Please check if you presently have or have had any of the following conditions in the past six months:

☐ Blurring of Vision	☐ Bronchitis	☐ Diarrhea	☐ Ringing In Ears
☐ Hiatus Hernia	☐ Constipation	☐ Headaches	☐ Heart Burn
☐ Dizziness	☐ Stomach Ulcer	☐ Urinary Frequency	☐ Sinusitis
☐ High Blood Pressure	☐ Varicose Veins	☐ Insomnia	☐ Chest Pains
☐ Asthma	☐ Diabetes	☐ Allergies	☐ Numbness or Tingling
☐ PMS	☐ Lower Back Pain	☐ Tendonitis	in Arms or Legs

Other health problems?_____
_____

List any surgery, accidents, falls or fractures, including year:_____
_____

Are you pregnant? Number of children? _____

List of medications you now take: _____
_____

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Current Condition/Primary Complaint:

Reason for attending office: _____

WCB Claim ☐ ICBC Claim ☐ Adjustor: _____

Area of main problem: _____

_____

_____

When did this condition begin? _____

Is it getting ☐ Better? ☐ Worse? ☐ Staying the Same? ☐ Comes and Goes?

Is this interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you had this before? ☐ Yes ☐ No If Yes, When?_____

Have you had treatment for this or previous episode? ☐ Yes ☐ No

If Yes, Where?_____

What aggravates your problem? _____

What alleviates it? _____

Is the problem: ☐ Constant? ☐ Intermittent?

Do you suffer from any condition other than that which you are now consulting us? _____

_____

_____

Have you had previous Chiropractic care? ☐ Yes ☐ No

Where? _____ When? _____

Why? _____ Were x-rays taken? ☐ Yes ☐ No

Have you had previous Massage Therapy care? ☐ Yes ☐ No

Where? _____ When? _____

Why? _____

Are you currently receiving care for this condition? ☐ Yes ☐ No

What type of care? _____

Have you previously worn orthotics? ☐Yes ☐ No

When? _____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

☐ Relief Care ☐ Correction ☐ Wellness

Patient's Signature:_____Date:_____

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