Intake Form

PATIENT INFORMATION

Name:		Date:	
Date of Birth:		Gender:	
Address:			
Home Phone:		Cell Phone:	
Email:		Occupation:	
How did you hear about us?		Preferred method for reminders:	☐ Call ☐ Text ☐ Email
Family Doctor:		Phone Number:	
Emergency Contact Name:		Relationship:	
Personal Health Number (PHN):		Do you have extended health coverage?	☐ Yes ☐ No
Please list your main health goals and concerns:			
Are any of your health concerns above part of an active **ICBC** or **WCB** Claim?	☐ Yes ☐ No	(If yes, please ask for additional form.)	

MEDICATION AND SUPPLEMENTS

Please list all current medications, supplements, vitamins/minerals, herbs or homeopathic remedies, along with daily dosages, length of use, reasons for taking and any side effects you may be experiencing. Please attach an additional page if needed.

Medications	Dose/Day	How Long?	Reason for Medication	Side Effects

Supplements	Dose/Day	How Long?	Reason for Supplement	Side Effects

Please indicate on the diagram below any areas of concern utilizing the following symbols:

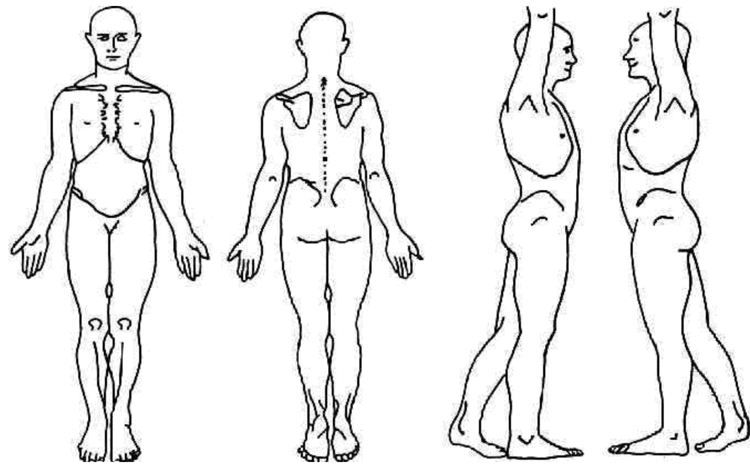
X for Sharp Pain

O for Dull, Aching Pain

S for Shooting Pain

B for Burning

T for Numbness or Tingling



CHIEF PHYSICAL CONCERN

Location of concern:		Initial cause of this concern:	
When did this concern begin?		Under doctor's care for concern?	
Does this concern or pain radiate or travel to other areas of the body?	☐ Yes ☐ No	Where?	
Do you have any numbness or tingling in your body?	☐ Yes ☐ No	Where?	
Intensity/Severity of pain (0-10, 10 being the worst):		How long does it last?	
Does this concern interfere with:	☐ Work ☐ Home life ☐ Activities ☐ Sleep		

PAST HEALTH HISTORY

Please check any of the following alternative therapies you have you previously received:			
☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Therapy ☐ Naturopathy ☐ Counselling ☐ Reflexology ☐ Other _______________			
Please list any major illnesses, trauma or injuries you have had in your life:			
Have you ever broken any bones?	☐ Yes ☐ No	If yes, please list:	
Do you suffer from any allergies?	☐ Yes ☐ No	If yes, please list:	
Have you undergone any surgeries?	☐ Yes ☐ No	If yes, please list dates and reason for surgery:	

FAMILY HEALTH HISTORY

Do you have a family history of medical conditions?	☐ Yes ☐ No	If yes, please list:
Have you been diagnosed with a hereditary condition?	☐ Yes ☐ No	If yes, please list:

Please check any conditions you have been diagnosed with:

- ☐ Alzheimer's
- ☐ Alcoholism
- ☐ Asthma
- ☐ Arthritis
- ☐ Anxiety/Nervousness
- ☐ Bone Fracture
- ☐ Chronic Fatigue
- ☐ Candida/Leaky Gut
- ☐ Crohn's or Colitis
- ☐ Cancer Type: _______________
- ☐ Chronic Ear Infections
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Depression
- ☐ Gall Bladder Problems or Removal
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease/Problems
- ☐ Multiple Sclerosis
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Sinus Condition
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: ___________________

Please check any symptoms you have experienced in the past 6 months:

- ☐ Numbness/Tingling
- ☐ Loss of smell
- ☐ Back/Neck pain
- ☐ Loss of taste
- ☐ Sleeping problems
- ☐ Numbness in fingers
- ☐ Nausea
- ☐ Shortness of breath
- ☐ Cold Feet
- ☐ Nervousness
- ☐ Extreme fatigue
- ☐ Cold hands
- ☐ Irritability
- ☐ Depression
- ☐ Cold sweats
- ☐ Dizziness
- ☐ Face flushed
- ☐ Loss of memory
- ☐ Chest pain
- ☐ Blurred vision
- ☐ Light bothers eyes
- ☐ Ringing in ears
- ☐ Fever
- ☐ Fainting
- ☐ Weight loss/gain
- ☐ Rashes/Skin changes
- ☐ Blood in stool/sputum
- ☐ Headaches
- ☐ Migraines

FEMALE CLIENTS

Are you currently trying to get pregnant?	☐ Yes ☐ No		
Are you pregnant?	☐ Yes ☐ No	If yes, how far along are you?	
Are you pre-menopausal or menopausal?	☐ Yes ☐ No	If yes, please list any symptoms your experiencing:	

CURRENT LIFESTYLE HABITS

What do you currently do for exercise?			
What is the frequency of these activities?			
Do you smoke?	☐ Yes ☐ No	If so, how often?	
Do you drink alcohol?	☐ Yes ☐ No	If so, how often?	

DAILY DIET CHOICES

Breakfast:		Lunch:	
Dinner:		Snacks:	

CLIENT STATEMENT

I, ______________________________, agree to allow this office to examine me for further evaluation.

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I also authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Cancellation Policy: Your appointment time has been reserved for you. In consideration of your therapist and fellow patients we ask that you provide ***24 hours' notice of cancellation or change to an appointment otherwise a fee will be charged***. Payment for all treatment(s) whether private or insured is ultimately the responsibility of the patient.

______________________________	______________________________
Patient Signature	Date