THE VILLAGE CLINIC

Date: ________________

New Chiropractic Patient Intake Form

Patient Information

Name: ________________________________ Preferred Name: ___________________________

Address: ______________________________ Occupation: _______________________________

City: _________________________________ Emergency Contact (Name): __________________

Province: _________ Postal Code: __________ Emergency Contact Number: __________________

Phone Number: _________________________ Is this a WCB Injury/Claim? ☐ No ☐ Yes

Email: _________________________________ Is this a ICBC Injury/Claim? ☐ No ☐ Yes

Birth Date: ______________ If Yes, when did the injury occur? _______________

Gender: ☐ Male ☐ Female ☐ Other: ________________

Medical Information

Family Medical Doctor Name: ____________________________ Clinic: _________________________

Date of last MD Visit: _______________________ Reason: _________________________________

Have you seen a chiropractor before? ☐ No ☐ Yes If Yes, who? ______________________________

Are you currently seeking any of the following care?

☐ Massage ☐ Acupuncture ☐ Physiotherapy ☐ Naturopathy ☐ MD ☐ Other: __________

How did you hear about us?

☐ Family/Friend ☐ Referred by MD ☐ Internet/Website ☐ Social Media ☐ Other: ________

Purpose of Visit

Reason for today's visit: ____

____

When and how did your symptoms start? ____

Have you had this before? ☐ No ☐ Yes; When? ____

Is it getting ☐ Better ☐ Worse ☐ Not changing

Rate your pain from 0-10 (0 is LEAST and 10 is WORST) _______________

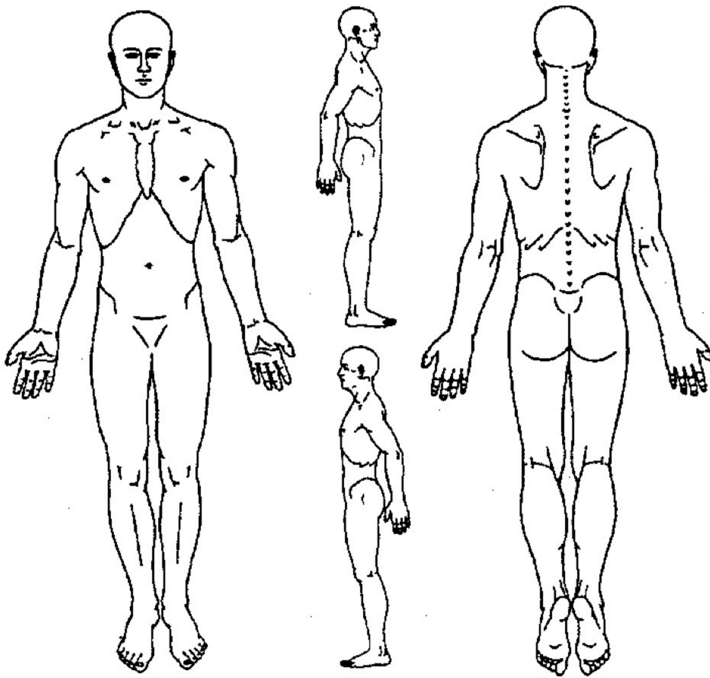
When do you feel the symptoms?

☐ Constantly ☐ Intermittently ☐ Worse in the morning ☐ Worse at night ☐ Disturbs sleep

Do the symptoms radiate down your legs or arms? ☐ No ☐ Yes; Where? _______________________

Date: _______________

On the diagram below, please fill in the areas in which you are currently experiencing symptoms:



Use the following symbols to indicate your symptoms on the diagram:

X Stiff/Tight
O Aching
~~ Numb/Tingling/Burning
Δ Sharp

Do any of the following **aggravate** your symptoms?

☐ Lifting	☐ Twisting	☐ Kneeling	☐ Sleeping
☐ Reaching	☐ Housework	☐ Driving	☐ Working
☐ Standing	☐ Walking	☐ Looking Up	☐ Other:
☐ Bending	☐ Sitting	☐ Looking Down	_______________

Do any of the following **relieve** your symptoms?

☐ Rest	☐ Walking	☐ Exercise	☐ Medication:
☐ Ice	☐ Movement	☐ Massage	_______________
☐ Heat	☐ Stretching	☐ Sleep	☐ Other:
☐ Standing	☐ Sitting	☐ Unknown	_______________

Have you seen anyone else for this condition?
☐ No ☐ Yes; Who? ____

Have you had any imaging/exams for this condition?
☐ Xray ☐ Ultrasound ☐ MRI ☐ CT
Date and Findings: ____

Is there anything else that you would like us to know about your condition?
____
____

Date: _______________

Medical History

Do you have a family history of:
☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Other: ________________________

Do you have any current illnesses or injuries? ☐ No ☐ Yes ___________________________________

Please list any previous serious injuries, illnesses, traumas, or surgeries and their dates:
____
____
____

Are you currently taking any medication/vitamins/supplements: ☐ No ☐ Yes ____________________
____

Do you have any allergies? ☐ No ☐ Yes ___________________________________

Do you have a personal history of:
☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Other: ________________________

Symptom Review

Please check the box for any conditions or symptoms that you have had **in the past 6 months**

General
- ☐ Fainting
- ☐ Headaches
- ☐ Fever
- ☐ Excessive sweating
- ☐ Rapid weight loss
- ☐ Night pain
- ☐ Loss of sleep
- ☐ Anxiety/ Nervousness

Genitourinary
- ☐ Difficulty urinating
- ☐ Blood in urine/stool
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Painful menstruation
- ☐ Irregular/absent cycle
- ☐ Menopause

Cardiovascular
- ☐ Chest pain
- ☐ Angina
- ☐ Ankle swelling
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat

Muscle/Joint
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Shoulder/arm pain
- ☐ Elbow pain
- ☐ Knee/leg pain
- ☐ Hip/groin pain
- ☐ Wrist/hand pain
- ☐ Ankle/foot pain
- ☐ TMJ/jaw pain
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Disc herniation
- ☐ Sciatica
- ☐ Gout

Neurological
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Nausea
- ☐ Convulsions
- ☐ Loss of balance

Gastrointestinal
- ☐ Poor/excessive appetite
- ☐ Belching/gas
- ☐ Vomiting
- ☐ IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's
- ☐ Heartburn

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Sinus infections
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Sore throat
- ☐ Frequent colds

Ears/Eyes/Nose/Throat
- ☐ Earaches/infection
- ☐ Tinnitus/ringing
- ☐ Difficulty hearing
- ☐ Worsening vision
- ☐ Eye pain