

TAILOR MADE WELLNESS CLINIC

#200, 85 Cranford Way
 Sherwood Park, AB T8H 0H9
 Phone: 780-464-5220

www.tailormadewellness.com

**CHIROPRACTIC
Adult Intake Form**

Alberta Healthcare #
 (required for clinic paperwork purposes)

Personal Information			
Name		Date	
Address			
City, Province		Postal Code	
Home Phone.		OK to leave messages? <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Cell Phone:		OK to leave messages? <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Birth Date:		Gender:	
Age:	Height:	Weight:	<input type="checkbox"/> Right handed / <input type="checkbox"/> Left handed
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Children: (Boys, Girls) <input type="checkbox"/> None			
Emergency Contact Information			
Emergency Contact:			
Phone		Relationship	
Work Information			
Occupation:			
Work Phone.		OK to leave messages? <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Employer:			
Work Address:			
Medications (Please list medication names where possible.)			
<input type="checkbox"/> Diuretics	<input type="checkbox"/> Heart medications	<input type="checkbox"/> Blood thinners	
<input type="checkbox"/> Birth control	<input type="checkbox"/> Accutane	<input type="checkbox"/> Muscle relaxants	
<input type="checkbox"/> Diabetes medication	<input type="checkbox"/> Osteoporosis medication	<input type="checkbox"/> Cholesterol medication	
<input type="checkbox"/> Hormones	<input type="checkbox"/> Other		
<input type="checkbox"/> Anti-inflammatories / Pain killers		<input type="checkbox"/> Tylenol / Anacin / Acetaminophen	
<input type="checkbox"/> Aspirin / ASA (acetylsalicylic acid) Bufferin		<input type="checkbox"/> Corticosteroids (prednisone, asthma drugs, etc.)	
<input type="checkbox"/> Advil / Ibuprophen		<input type="checkbox"/> Other	
<input type="checkbox"/> I am currently not taking any medications			
Vitamins / Herbs / Supplements (Please list.)		Allergies (Please list.)	
<input type="checkbox"/> I am currently not taking any vitamins or supplements.			

Primary concern	
What is your <u>primary concern</u> today?	How long?
<i>Please describe the character of your pain:</i>	
<input type="checkbox"/> Dull	<input type="checkbox"/> Aching
<input type="checkbox"/> Sharp	<input type="checkbox"/> Pulling
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Burning
<input type="checkbox"/> Nagging	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Pins & needles	<input type="checkbox"/> Weakness
Is this a Workers Compensation Case?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Is this a Motor Vehicle Accident Case?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Do you have extended health insurance?	<input type="checkbox"/> Yes (with _____) / <input type="checkbox"/> No
Whom may we thank for referring you to our office?	

Which activities WORSEN your pain?		
<input type="checkbox"/> Worst in morning	<input type="checkbox"/> Lying flat	<input type="checkbox"/> Rising from sitting
<input type="checkbox"/> Worst in afternoon	<input type="checkbox"/> Standing	<input type="checkbox"/> Stress (mental/emotional)
<input type="checkbox"/> Worst in evening	<input type="checkbox"/> Sitting	<input type="checkbox"/> Exercising/stretching
<input type="checkbox"/> Worst during sleep	<input type="checkbox"/> Walking	<input type="checkbox"/> Poor posture
<input type="checkbox"/> Worst at rest	<input type="checkbox"/> Other	

Which activities IMPROVE your pain?		
<input type="checkbox"/> Lying flat	<input type="checkbox"/> Sitting	<input type="checkbox"/> Exercising/stretching
<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Other

Has your pain been associated with any of the following		
<input type="checkbox"/> Excessive fatigue or malaise	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Pain with urination
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Fever (incl. low grade)	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Balance problems
<input type="checkbox"/> Night pain	<input type="checkbox"/> Kidney pain	

General Health History		
Please check all additional concerns that apply:	How long?	How long?
<input type="checkbox"/> Headaches / Migraines		<input type="checkbox"/> Arm/hand pain, numbness, tingling
<input type="checkbox"/> Neck pain, soreness or stiffness		<input type="checkbox"/> Chest wall pain
<input type="checkbox"/> Upper back pain, soreness, stiffness		<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Lower back pain, soreness, stiffness		<input type="checkbox"/> Leg/foot pain, numbness, tingling
<input type="checkbox"/> Hip pain		<input type="checkbox"/> Other

Have you ever been to a Doctor of Chiropractic for any condition? Yes (when? _____) / No

If yes, Doctor's name: _____ Were treatments helpful? Yes / No

Have you ever been treated by:		
<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> Naturopathic doctor	<input type="checkbox"/> Physiotherapist
<input type="checkbox"/> Allergist	<input type="checkbox"/> Neurologist	<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Homeopath	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Hypnotherapist	<input type="checkbox"/> Orthopaedic surgeon	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Massage therapist	<input type="checkbox"/> Orthotist	

When was your last physical exam by a medical doctor?

Doctor's name:

Notable tests/results?

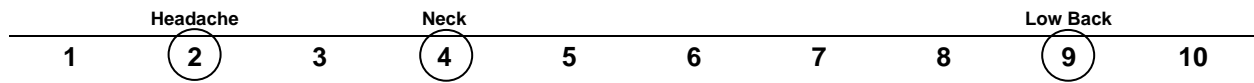
Do you exercise			
<input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> I lift weights (gym/home)		
<input type="checkbox"/> 3 or more times weekly	<input type="checkbox"/> I do cardiovascular workouts		
<input type="checkbox"/> I do NOT exercise	<input type="checkbox"/> I stretch regularly		
Orthotic use			
Have you ever been fitted for orthotics? <input type="checkbox"/> Yes / <input type="checkbox"/> No		Are you wearing them now? <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Review of systems			Year
<input type="checkbox"/> I bruise easily			n/a
<input type="checkbox"/> Crohn's / Colitis / IBD <input type="checkbox"/> Stomach/duodenal ulcers <input type="checkbox"/> Constipation			
<input type="checkbox"/> Asthma, emphysema or COPD			
<input type="checkbox"/> Smoke cigarettes or chew tobacco (<input type="checkbox"/> currently / <input type="checkbox"/> past)			
<input type="checkbox"/> Diabetes / hypoglycemia <input type="checkbox"/> Thyroid condition <input type="checkbox"/> Kidney / liver disease			
<input type="checkbox"/> Heart attack, heart disease, pacemaker or neck/chest shunt/stent			
<input type="checkbox"/> Stroke / transient ischemic attack (TIA)			
<input type="checkbox"/> Epilepsy / seizures / convulsion disorder <input type="checkbox"/> Concussions / coma			
<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Gout <input type="checkbox"/> Spinal meningitis			
<input type="checkbox"/> Cancer (type: _____)			
<input type="checkbox"/> Scoliosis, spondylolisthesis, spina bifida or fused vertebrae			
<input type="checkbox"/> Bulging or herniated disc or disc degeneration in spine (<input type="checkbox"/> cervical / <input type="checkbox"/> lumbar)			
<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic fatigue syndrome			
<input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Amyotrophic lateral sclerosis (ALS) <input type="checkbox"/> Lupus/SLE			
<input type="checkbox"/> Rheumatoid arthritis (joints or spine) <input type="checkbox"/> Osteoarthritis (joints or spine)			
<input type="checkbox"/> Osteoarthritis			
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Ankylosing spondylitis			
Women			
<input type="checkbox"/> Any type of breast implants.			
<input type="checkbox"/> Any chance you might be pregnant.			
Men			
<input type="checkbox"/> Recent prostate or urinary/genital problems.			
Prior injury history			
<input type="checkbox"/> Work injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Pedestrian injury	
<input type="checkbox"/> Lifting injury	<input type="checkbox"/> Bicycle injury	<input type="checkbox"/> Military injury	
<input type="checkbox"/> Motorcycle injury	<input type="checkbox"/> Motorvehicle accident	<input type="checkbox"/> Sports injury	
<input type="checkbox"/> I have had no prior injuries in the past.			
Fractures / Broken bones		Year	Year
<input type="checkbox"/> Spinal / vertebral		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone / clavicle		<input type="checkbox"/> Rib	
<input type="checkbox"/> Arm / hand		<input type="checkbox"/> Leg / foot	
<input type="checkbox"/> Pelvic bone		<input type="checkbox"/> Other	
<input type="checkbox"/> I have no history of broken bones.			
Surgeries		Year	Year
<input type="checkbox"/> Spine (neck or back)		<input type="checkbox"/> Appendix / Gallbladder	
<input type="checkbox"/> Disc (neck or back)		<input type="checkbox"/> Liver / stomach / kidney	
<input type="checkbox"/> Heart / chest		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib / collarbone	
<input type="checkbox"/> Head / brain / spinal cord / nerve		<input type="checkbox"/> Hernia (inguinal /hiatal)	
<input type="checkbox"/> Shoulder / arm / wrist / hand		<input type="checkbox"/> Other	
<input type="checkbox"/> I have no history of surgical procedure.			

Sleep habits / information		
Are you sleeping on:	<input type="checkbox"/> Box spring mattress	<input type="checkbox"/> Water bed
	<input type="checkbox"/> Foam mattress	<input type="checkbox"/> Other
Type of pillow:	<input type="checkbox"/> Feather	<input type="checkbox"/> Foam
	<input type="checkbox"/> Contour	<input type="checkbox"/> Buckwheat
	<input type="checkbox"/> Other	
Normal sleep pattern:	<input type="checkbox"/> Poor, awoken tired	<input type="checkbox"/> Rested less than 6 hrs.
	<input type="checkbox"/> Rested after 6-8 hrs.	<input type="checkbox"/> Need more than 10 hrs.
	<input type="checkbox"/> Tend to sleep flat on stomach	

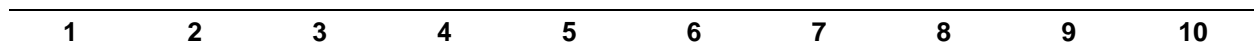
Quadruple Visual Analogue Scale

Please circle the number which best describes the question being asked. NOTE: If you have more than one complaint, please answer the questions for each complaint individually and indicate which score is for which complaint.

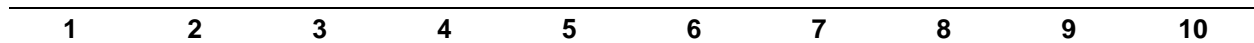
Example:



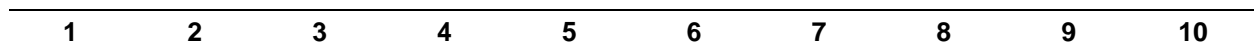
What is your pain RIGHT NOW?



What is your TYPICAL or AVERAGE pain?

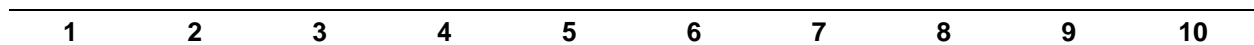


What is your pain AT IT'S BEST? (IE: How close to "0" does your pain get at it's best?)



What percentage of your awake hours is your pain at it's best? _____

What is your pain AT IT'S WORST? (How close to "10" does your pain get at it's best?)



What percentage of your awake hours is your pain at it's worst? _____

Pain Drawing

It is important that your Chiropractic Doctor knows where you have stiffness, numbness, tingling and any type of pain. Please mark the areas on the figures below that correspond to any pain or altered sensation you're experiencing.

1. Show area(s) of pain or unusual feeling. If the pain you're experiencing travels or "shoots" use arrows to indicate how far it travels.
2. Use the appropriate symbols to mark the area(s) on this body where you feel the described sensations. Include all affected areas.

Numbness N N N N N
 Stiffness S S S S S
 Burning X X X X X
 Stabbing / / / / /

Tingling T T T T T
 Pins and Needles P P P P P
 Aching A A A A A

