TAILOR MADE WELLNESS CLINIC

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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? ☐ Yes / ☐ No	
Cell Phone:		OK to leave messages? ☐ Yes / ☐ No	
Birth Date:		Gender:	
Age:	Height:	Weight:	☐ Right handed / ☐ Left handed

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

Children: (Boys, Girls) ☐ None

Emergency Contact Information

Emergency Contact:	
Phone	Relationship

Work Information

Occupation:	
Work Phone.	OK to leave messages? ☐ Yes / ☐ No
Employer:	
Work Address:	

Medications (Please list medication names where possible.)

☐ Diuretics	☐ Heart medications	☐ Blood thinners
☐ Birth control	☐ Accutane	☐ Muscle relaxants
☐ Diabetes medication	☐ Osteoporosis medication	☐ Cholesterol medication
☐ Hormones	☐ Other	

☐ Anti-inflammatories / Pain killers

- ☐ *Aspirin / ASA (acetylsalicylic acid) Bufferin*
- ☐ *Advil / Ibuprophen*
- ☐ *Tylenol / Anacin / Acetominophen*
- ☐ *Corticosteroids (prednisone, asthma drugs, etc.)*
- ☐ *Other*

☐ I am currently not taking any medications

Vitamins / Herbs / Supplements (Please list.)	Allergies (Please list.)

☐ I am currently not taking any vitamins or supplements.

Primary concern

What is your primary concern today? _____ ***How long?*** _____

Please describe the character of your pain:

☐ Dull ☐ Aching ☐ Stabbing ☐ Burning ☐ Pins & needles
☐ Sharp ☐ Pulling ☐ Nagging ☐ Throbbing ☐ Weakness

Is this a Workers Compensation Case? ☐ Yes / ☐ No

Is this a Motor Vehicle Accident Case? ☐ Yes / ☐ No

Do you have extended health insurance? ☐ Yes (with _____) / ☐ No

Whom may we thank for referring you to our office?

Which activities WORSEN your pain?

☐ Worst in morning	☐ Lying flat	☐ Rising from sitting
☐ Worst in afternoon	☐ Standing	☐ Stress (mental/emotional)
☐ Worst in evening	☐ Sitting	☐ Exercising/stretching
☐ Worst during sleep	☐ Walking	☐ Poor posture
☐ Worst at rest	☐ Other	

Which activities IMPROVE your pain?

☐ Lying flat	☐ Sitting	☐ Exercising/stretching
☐ Standing	☐ Walking	☐ Other

Has your pain been associated with any of the following

☐ Excessive fatigue or malaise	☐ Abdominal pain	☐ Pain with urination
☐ Weight loss	☐ Bowel or bladder disorders	☐ Night sweats
☐ Fever (incl. low grade)	☐ Ovarian pain	☐ Balance problems
☐ Night pain	☐ Kidney pain	

General Health History

Please check all additional concerns that apply:	**How long?**		**How long?**
☐ Headaches / Migraines		☐ Arm/hand pain, numbness, tingling	
☐ Neck pain, soreness or stiffness		☐ Chest wall pain	
☐ Upper back pain, soreness, stiffness		☐ Shoulder pain	
☐ Lower back pain, soreness, stiffness		☐ Leg/foot pain, numbness, tingling	
☐ Hip pain		☐ 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:

☐ Acupuncturist	☐ Naturopathic doctor	☐ Physiotherapist
☐ Allergist	☐ Neurologist	☐ Podiatrist
☐ Homeopath	☐ Ophthalmologist	☐ Psychiatrist
☐ Hypnotherapist	☐ Orthopaedic surgeon	☐ Psychologist
☐ Massage therapist	☐ Orthotist	

When was your last physical exam by a medical doctor?

Doctor's name:

Notable tests/results?

Do you exercise	
☐ 1-2 times weekly	☐ I lift weights (gym/home)
☐ 3 or more times weekly	☐ I do cardiovascular workouts
☐ I do NOT exercise	☐ I stretch regularly

Orthotic use	
Have you ever been fitted for orthotics? ☐ Yes / ☐ No	Are you wearing them now? ☐ Yes / ☐ No

Review of systems	**Year**
☐ I bruise easily	**n/a**
☐ Crohn's / Colitis / IBD ☐ Stomach/duodenal ulcers ☐ Constipation	
☐ Asthma, emphysema or COPD	
☐ Smoke cigarettes or chew tobacco (☐ currently / ☐ past)	
☐ Diabetes / hypoglycemia ☐ Thyroid condition ☐ Kidney / liver disease	
☐ Heart attack, heart disease, pacemaker or neck/chest shunt/stent	
☐ Stroke / transient ischemic attack (TIA)	
☐ Epilepsy / seizures / convulsion disorder ☐ Concussions / coma	
☐ Eczema ☐ Psoriasis ☐ Gout ☐ Spinal meningitis	
☐ Cancer (type:)	
☐ Scoliosis, spondylolisthesis, spina bifida or fused vertebrae	
☐ Bulging or herniated disc or disc degeneration in spine (☐ cervical / ☐ lumbar)	
☐ Fibromyalgia ☐ Chronic fatigue syndrome	
☐ Multiple sclerosis ☐ Amyotrophic lateral sclerosis (ALS) ☐ Lupus/SLE	
☐ Rheumatoid arthritis (joints or spine) ☐ Osteoarthritis (joints or spine)	
☐ Osteoarthritis	
☐ Osteoporosis ☐ Osteopenia ☐ Ankylosing spondylitis	

Women
☐ Any type of breast implants.
☐ Any chance you might be pregnant.

Men
☐ Recent prostate or urinary/genital problems.

Prior injury history		
☐ Work injury	☐ Fall	☐ Pedestrian injury
☐ Lifting injury	☐ Bicycle injury	☐ Military injury
☐ Motorcycle injury	☐ Motorvehicle accident	☐ Sports injury
☐ I have had no prior injuries in the past.		

Fractures / Broken bones	**Year**		**Year**
☐ Spinal / vertebral		☐ Skull	
☐ Collar bone / clavicle		☐ Rib	
☐ Arm / hand		☐ Leg / foot	
☐ Pelvic bone		☐ Other	
☐ I have no history of broken bones.			

Surgeries	**Year**		**Year**
☐ Spine (neck or back)l		☐ Appendix / Gallbladder	
☐ Disc (neck or back)		☐ Liver / stomach / kidney	
☐ Heart / chest		☐ Cancer	
☐ Tonsillectomy		☐ Rib / collarbone	
☐ Head / brain / spinal cord / nerve		☐ Hernia (inguinal /hiatal)	
☐ Shoulder / arm / wrist / hand		☐ Other	
☐ I have no history of surgical procedure.			

Sleep habits / information		
Are you sleeping on:	☐ Box spring mattress	☐ Water bed
	☐ Foam mattress	☐ Other
Type of pillow:	☐ Feather	☐ Foam
	☐ Contour	☐ Buckwheat
	☐ Other	
Normal sleep pattern:	☐ Poor, awaken tired	☐ Rested less than 6 hrs.
	☐ Rested after 6-8 hrs.	☐ Need more than 10 hrs.
	☐ 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:

Headache Neck Low Back

1 (2) 3 (4) 5 6 7 8 (9) 10

What is your pain RIGHT NOW?

1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

1 2 3 4 5 6 7 8 9 10

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

1 2 3 4 5 6 7 8 9 10

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?)

1 2 3 4 5 6 7 8 9 10

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	Tingling	T T T T T
Stiffness	S S S S S	Pins and Needles	P P P P P
Burning	X X X X X	Aching	A A A A A
Stabbing	/ / / / / /