

Patient Intake Form

Name: _____ Date: _____

Date of Birth: ____/____/____ (DD/MM/YYYY) Male Female

Address: _____

City: _____ Postal Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

May we add you to our seasonal newsletter and calendar of events via email? Your email address will not be shared. Yes No

Occupation _____

Do you primarily sit or stand at work? _____ Height: _____

Do you use a computer for long periods at work? Yes No Weight: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to you: _____

Family Doctor

Name: _____ Phone: _____

Address: _____

Date of last appt./physical: _____

Other Health Care Professionals

(Medical specialist, naturopath, homeopath, physiotherapist, massage therapist, etc.)

Name: _____ Phone: _____

Professional Designation: _____

Address: _____

Date of last appt./physical: _____

Name: _____ Phone: _____

Professional Designation: _____

Address: _____

Date of last appt./physical: _____

Primary Complaint

What is your current concern? _____

Where do you feel the discomfort? _____

How would you describe the pain? _____
(stabbing, dull, achy, stiff & tight, burning, etc.)

Does the pain travel to other parts of the body? _____

When did it occur? _____ How did it occur? _____

Is it getting better, worse or staying the same? _____

Have you seen other health professionals regarding this complaint? And if so, whom?

What treatment did they use? _____

Have you taken medication for this complaint? Yes No

Have you ever experienced this complaint before? Yes No If yes, when? _____

Did you receive any treatment at the time? Yes No

Have you had x-rays in relation to the current complaint? Yes No

Is this an injury that occurred at work? Yes No If yes, was it reported? Yes No

Is this an injury as a result of a motor vehicle accident? Yes No

If yes, is there a claim pending? Yes No

Lifestyle

Have you ever been to a chiropractor previously? Yes No

If yes, when was your last treatment? _____

Do you currently take any prescription medication? Yes No

If yes, please specify which: _____

Do you currently take any over the counter medication? Yes No

If yes, please specify which: _____ For what complaint? _____

How often do you take this medication? _____

Do you currently take any vitamins or nutritional supplements? Yes No

If yes, please specify: _____

Do you exercise? Yes No If yes, how often? _____

Do you smoke? Yes No If yes, how many per day or week? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Any prior surgeries? Yes No _____

Any prior hospitalizations? Yes No _____

Have you broken any bones? Yes No If yes, please specify: _____

Do you have any known allergies to oils or skin creams? Yes No

Client Health History

Please CHECK anything which is currently causing you problems / concern.
Please CIRCLE anything which has been a problem / concern in the past.

- | | | |
|--|---|--|
| <input type="checkbox"/> Persistent Fatigue | <input type="checkbox"/> Headache | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sweats | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of strength |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Elbow Pain R / L |
| <input type="checkbox"/> TMJ Pain R / L | <input type="checkbox"/> Shoulder Pain R / L | <input type="checkbox"/> Neck Pain R / L |
| <input type="checkbox"/> Wrist Pain R / L | <input type="checkbox"/> Hand Pain R / L | <input type="checkbox"/> Hip Pain R / L |
| <input type="checkbox"/> Mid back Pain R / L | <input type="checkbox"/> Low Back Pain R / L | <input type="checkbox"/> Foot Pain R / L |
| <input type="checkbox"/> Knee Pain R / L | <input type="checkbox"/> Ankle Pain R / L | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Spitting up blood | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Deafness | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Enlarged lymph glands | <input type="checkbox"/> Speech problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Heat / cold intolerance |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Heart or blood disease | <input type="checkbox"/> Easily bruise |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Hives | <input type="checkbox"/> Belching or gas |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Infectious skin disease | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Eczema / Psoriasis | <input type="checkbox"/> Hemophilia | |

Women Only

- | | | |
|---|--|---|
| <input type="checkbox"/> Breast lump / pain | <input type="checkbox"/> Severe menstrual cramps | <input type="checkbox"/> Loss of menstruation |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Irregular cycles | |

Family History

Have your grandparents, parents or siblings ever been diagnosed with the following:

- High blood pressure High cholesterol Heart disease
- Stroke Diabetes (Type I or Type II) Thyroid problems
- Hormone problems Breathing or Lung problems Rheumatoid Arthritis
- Osteoarthritis Cancer Kidney Disease
- Neurological conditions
(ALS, MS, Parkinson's, CP, TBI) Other _____

Females Only

Are you currently pregnant? Yes No Number of pregnancies: _____

Number of children: _____

Have you ever taken any pharmaceutical forms of birth control? Yes No

Are you currently taking any pharmaceutical forms of birth control? Yes No

Males Only

If over the age of 50, have you ever had your prostate examined by a medical doctor? Yes No

Do you have regular prostate exams? Yes No

What would you like to achieve by coming to Village Wellness?

Our primary goal is to work towards the resolution of your current condition as quickly as possible through excellent health care and patient education while helping to prevent you from experiencing this condition again.

Do you have any specific concerns about the therapies that we provide?

We will always give a thorough explanation of what we've found in our history and physical exam; explain the condition we believe you to be suffering from as well as the treatment options available to you, the expected outcome and any risks involved. Always feel free to ask questions at any stage of your treatment, Good communication is an important part of the treatment and prevention process at Village Wellness.

I hereby authorize the health care professionals at Village Wellness, with my prior knowledge, to release to or obtain any health information from my other health care providers as may be required for the management of my case.

I have read and understood the Village Wellness at Appaloosa fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Client Signature: _____

Date: _____