Please thoroughly complete the following form to assist us in treating you accurately and safely.

Confidential Patient Intake Form

Name:			Today's Date (D/M/Y):
Address:		City:	Postal Code:
Home Ph.	Cell Ph.	Business Ph.	Ext.
Email:			
Date of Birth (D/M/Y):		Age:	O Male O Female
Occupation:		Employer:	
Medical Doctor:	Health Card #:		Expiry:

O Work related injury/accident (WSIB) O Motor vehicle accident (MVA) Date of Accident:

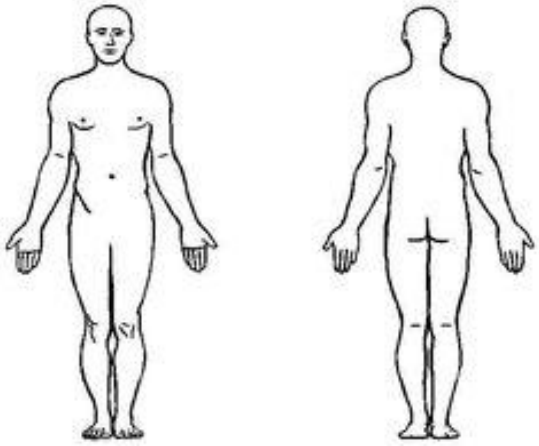
Previous Therapy: O Chiropractic O Acupuncture O Physiotherapy O Message Therapy O Other
Last Visit? Practitioner's name/clinic:

Reason for visit?

What do you believe caused this?	When did it occur?

Associated Symptoms?

Please mark the area(s) of pain or discomfort on the drawing using the symbols provided in the legend.



Burning
O Numbness and tingling
V Sharp and stabbing
/ Dull and aching

What makes it better?

What makes it worse?

Frequency of Pain: O Infrequent <25% O Occasional 25-50% O Frequent 50-75% O Constant >75%

On average, how intense has your pain been **over the last week**? Circle one.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Medical History

Please check off any and all conditions you have or have had in the past.

Musculoskeletal	Cardiovascular/Lung:	Gastrointestinal:	Disease:
○ Bone fracture ○ Dislocated joint ○ Fibromyalgia ○ Weakness ○ Numbness/tingling ○ Osteopenia ○ Osteoporosis ○ Osteoarthritis ○ Rheumatoid arthritis ○ Peripheral neuropathy ○ Multiple sclerosis ○ Scoliosis ○ Spinal disc disease ○ Artificial joint/ pins/screws	○ Anemia ○ Asthma ○ Bleeding disorder ○ Bronchitis ○ COPD ○ Heart disease ○ High blood pressure ○ Low blood pressure ○ Lung/breathing problems ○ Mechanical heart valve ○ Pacemaker ○ Shortness of breath ○ Stroke/ TIA ○ Varicose veins **Skin:** ○ Easily Bruised ○ Rash ○ Other	○ Unexplained weight loss ○ Unexplained weight gain ○ Crohn's ○ Colitis diverticulitis ○ GERD/GORD ○ Heartburn ○ Hepatitis ○ Irritable Bowel ○ Ulcer **Genitourinary:** ○ Kidney trouble ○ Prostate trouble ○ Sexual dysfunction ○ STDs ○ Pregnant- Due date: _____ Number of pregnancies: _____	○ AIDS/HIV ○ Allergies ○ Eczema/Psoriasis ○ Cancer ○ Diabetes ○ Epilepsy ○ Fainting ○ Headache ○ Hepatitis A B C D ○ Insomnia ○ Mental/emotion difficulty ○ Polio ○ Rheumatic fever ○ Sinus trouble ○ Thyroid trouble ○ Tinnitus ○ Tuberculosis ○ Vertigo

Have you had any major surgeries or operations? ○No ○Yes
If yes, please describe what and when it occurred.

Please list all prescription and non-prescription medications that you are currently taking.

How did you hear about our office?
○Patient/Family/Friend ○Health Professional ○Google ○Other:_____

Thank you!