NORTHERN FAMILY
CHIROPRACTIC & REHAB

Adult New Patient Confidential Intake Form

Date: _____ (mm/dd/yyyy) _____

Last name: _____ **First Name:** _____

Address: _____

Suite/Apt #: _____ **City:** _____ **Postal Code:** _____

Home Phone #: _____ **Work Phone #:** _____

Cell Phone #: _____ **Email:** _____

Date of Birth: ___/___/___ **Gender:** _____
mm/dd/yyyy

Medical Doctor: _____ (Name) _____ (Address) _____
Permission to send medical doctor a progress letter, if needed: YES / NO

Occupation: _____

Emergency Contact Name: _____ **Tel.:** _____

Relationship: _____

How did you hear about our clinic?

- ☐ Friend or Acquaintance (name): _____
- ☐ Family member (name): _____
- ☐ Another Health Professional (please specify): _____
- ☐ Our Signage
- ☐ Our website
- ☐ Facebook/Instagram
- ☐ Other (please specify): _____

16 9th Street
Hearst, ON
P0L1N0
(705) 362-5352

105A Brunelle Road North
Kapuskasing, ON
P5N 2M1
(705) 371-2223

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Areas ofConcern

Some patients come to us in pain, others to improve their performance. How can we help you?

- ☐ I have had a recent injury. I am in pain and in need of help.
- ☐ I am suffering from an old injury.
- ☐ I am not sure what I have done but my pain is getting worse.
- ☐ My body no longer moves like it used to.
- ☐ I am not in pain. I wish to improve my physical abilities.
- ☐ I am interested in a wellness check-up.

Please list/describe the location of your symptoms in order of severity:

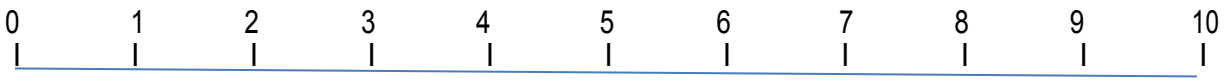
1) _____

2) _____

3) _____

How and when did your condition begin?

If you are experiencing pain, please rate your current pain level on this 10 point scale 10 = severe pain (worst of your life), 0 = no pain



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How would you describe your symptoms?

☐ Sharp pain
☐ Dull pain
☐ Numbness/Tingling
☐ Weakness
☐ Stabbing pain
☐ Shooting pain
☐ Achiness
☐ Stiffness
☐ Pressure/Throbbing
☐ Burning pain
☐ Loss of motion or function
☐ Aggravated with movement
☐ Improves with movement
☐ Other: _____

Tell us about your lifestyle. Do you…

☐ Live an active lifestyle
☐ Live a sedentarylifestyle
☐ Have a low cardio-aerobic fitness
☐ Smoke? If so, how many cigarettes per day _____
☐ Have you ever smoked before?
☐ Drink alcohol? If so, how many drinks per day_____or perweek _____
☐ Exercise daily?
☐ Exercise weekly?
☐ Do you practice any sports/hobbies? _____
☐ Get enough sleep? How many hours per night _____
☐ Do you wake feeling rested?
☐ Do you eat a well-balanced diet?
☐ Are you on any specific diet? If so which one? _____

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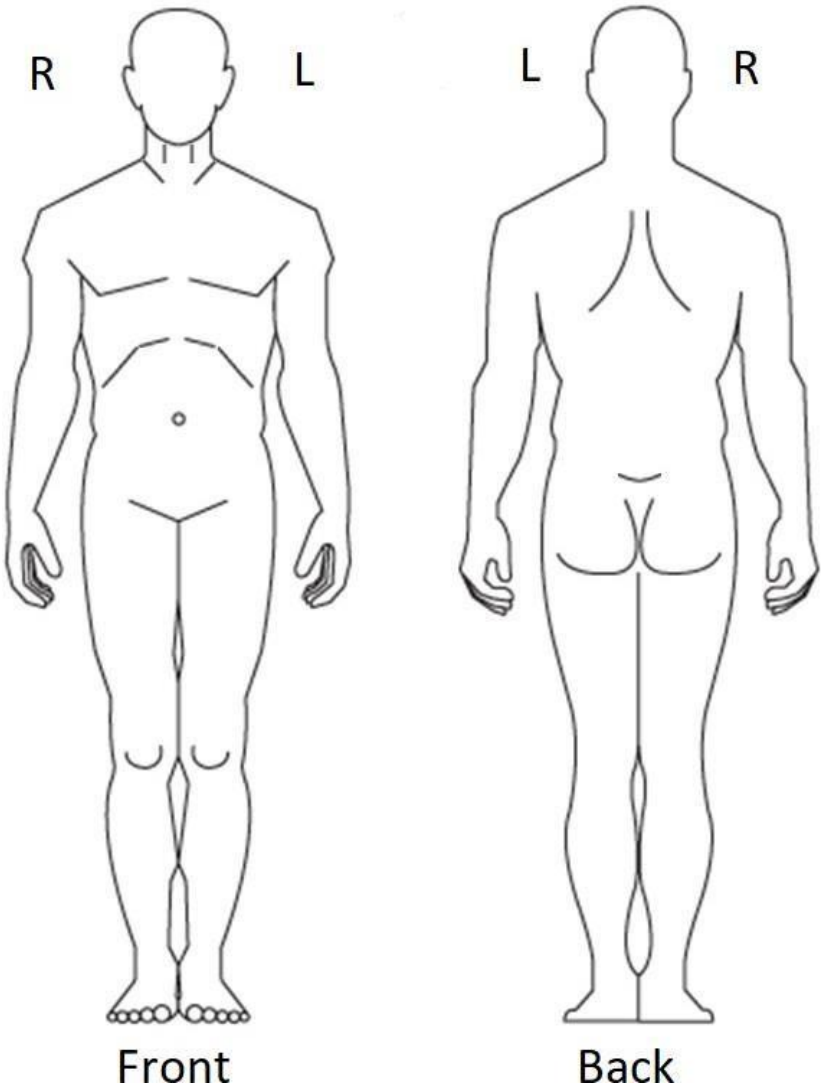
Symptom Diagram

Patient Name:_____ **Date:** _____

In the diagram provided below, please mark the areas on your body, which you feel best represents the pain(s) or sensation(s) you are experiencing. Please include all areas. In addition, please draw in your face to complete the diagram.



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I have moments in my day without pain.

☐ Yes

☐ No

My condition interferes with my day-to-day activities:

☐ No, not at all

☐ Somewhat

☐ Moderately

☐ Yes, considerably

What provides you with relief?

Who else have you seen for your current condition?

☐ Family doctor
☐ Orthopedic specialist
☐ Neurologist
☐ Rheumatologist
☐ Sports Medicine MD
☐ Chiropractor
☐ Physiotherapist
☐ Massage therapist
☐ Naturopath
☐ Other: _____

Are you currently taking any medications? If so, please list:

-
-
-
-

If medications list is extensive, please provide the clinic with a copy of entire list.

How would you rate your overall health? Excellent / Good / Declining / Poor

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Understanding your family medical history will help us support your health. Do any of your immediate family members suffer from:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Autoimmune disorders
- ☐ Cardiovascular disease
- ☐ Stroke
- ☐ Hypertension
- ☐ Other: _____

Have you been diagnosed with any of the following (currently (X) or in the past (√) ?

Gastrointestinal
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Vomiting
- ☐ Constipation
- ☐ Jaundice
- ☐ Ulcers
- ☐ Diabetes
- ☐ Diarrhea

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Problem Speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Clumsiness
- ☐ Numbness/tingling

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bed wetting
- ☐ Prostate trouble

Cardiovascular
- ☐ Bleeding disorder
- ☐ Hypertension
- ☐ Stroke
- ☐ DVT/Blood clot
- ☐ Chest Pain
- ☐ Angina
- ☐ Varicose veins
- ☐ Swelling in ankles
- ☐ Poor circulation

GU for women
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycles
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breast
- ☐ Lump in breast

Currently/Previously on birth control?
- ☐ Yes
- ☐ No

Number of pregnancies:____

Number of children: _____

Muscles and Joints
- ☐ Sore/stiff neck
- ☐ Mid backache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot pain
- ☐ Arthritis
- ☐ Loss of strength

General symptoms
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess sweating
- ☐ Night sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Nervousness
- ☐ Convulsion
- ☐ Generalized pain

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm

Skin
- ☐ Rashes/itching
- ☐ Bruises easily
- ☐ Dryness

Eyes/Ear/Nose/Throat
- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Ear pain
- ☐ Ring/buzz in ear
- ☐ Frequent colds
- ☐ Enlarged thyroid/gland
- ☐ HIV/AIDS
- ☐ Infection
- ☐ Kidney disease

Have you ever been diagnosed with:
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hepatitis A/B/C
- ☐ Mental Health Concerns

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Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree.

Cancellation Policy

Your appointment time is reserved for you. We respectfully request 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee.

☐ I am aware of the Cancellation Policy.

Please read the following statements: then check off each box and sign below:

☐ Chiropractic treatment may be covered under extended health insurance at work, and or no fault insurance (motor vehicle accident), or WSIB (inured at work), however; in the event that the third party billing does not cover my treatment fees I hereby confirm that I am responsible for any outstanding balances.

☐ I have answered all questions and filled in areas that have requested information. The information supplied by me in this questionnaire is accurate and complete. I understand that the withholding of health care information could jeopardize my receiving safe and effective treatment.

☐ The chiropractors at Northern Family Chiropractic & Rehab work together as a team, and often collaborate with each other regarding their patients' diagnosis and care. I hereby consent to my Northern Family Chiropractic & Rehab Health Care Provider to collaborate on my case.

☐ In the event I am not able to answer the phone when called by the staff of Northern Family Chiropractic & Rehab, I hereby authorize the staff to leave a message for me regarding the details of my appointment at the phone numbers provided.

☐ I hereby give my consent for Northern Family Chiropractic & Rehab to either obtain or release medical information as deemed necessary, in accordance with privacy policies.

Signature:_____ **Date:** _____

Witness:_____ **Date:** _____

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