



1180 FIR STREET CAMPBELL RIVER, BC V9W 3B8  
250-287-8487

CONFIDENTIAL PATIENT INTAKE FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Birth Date (D/M/Y): \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  D  W  
 S

Your Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

B.C. Care Card Personal Health Number: \_\_\_\_\_

How did you hear about our office?  Friend or family member(who?): \_\_\_\_\_

Medical referral: \_\_\_\_\_  Yellow pages  Sign  Other: \_\_\_\_\_

ARE YOU OR WILL YOU BE ON ICBC OR WCB?:

1. Recent motor vehicle accident (ICBC):  Yes  No (if Yes, please see receptionist)

2. Work related injury/accident (WCB):  Yes  No (if Yes, please see receptionist)

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?:  Yes  No

If Yes who?: \_\_\_\_\_ And when? \_\_\_\_\_

Condition you were seen for?: \_\_\_\_\_

What results did you obtain with care?:  Excellent  Good  Fair  Poor

MEDICAL DOCTOR:

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Date of last Appointment: \_\_\_\_\_



1180 FIR STREET CAMPBELL RIVER, BC V9W 3B8  
250-287-8487

**CURRENT HEALTH CONDITION**

What health concern has brought you to our office? \_\_\_\_\_

Please describe the pain and it's location: \_\_\_\_\_

How long has this been bothering you? \_\_\_\_\_ Is it getting worse?  Yes  No  Off and On  Constant

Is this condition affecting your:  Work  Sleep  Daily Routine? If yes please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No If yes please explain: \_\_\_\_\_

What other treatment have you already received for your condition?  Medication  Surgery  Physio Therapy  
 Chiropractic  Massage  None  Other: \_\_\_\_\_

**HEALTH HISTORY**

**PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD BEFORE OR HAVE NOW:**

- |                                               |                                                |                                               |                                            |
|-----------------------------------------------|------------------------------------------------|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Aids/HIV             | <input type="checkbox"/> Fever(prolonged)      | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> Sinus Infections  |
| <input type="checkbox"/> Allergy Shots        | <input type="checkbox"/> Frequent colds        | <input type="checkbox"/> Menopause            | <input type="checkbox"/> Severe Fall       |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Midback Pain         | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Aneurysm             | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Surgery           |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hearing problems      | <input type="checkbox"/> Numbness             | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Breast Conditions    | <input type="checkbox"/> Heart conditions      | <input type="checkbox"/> On Medication        | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Vision problems   |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Herniated Disc        | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/>                   |
| <input type="checkbox"/> Car Accident         | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Painful Menses       | Other: _____                               |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Pinched Nerve        | _____                                      |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hysterectomy          | <input type="checkbox"/> Pneumonia            | _____                                      |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Intestinal conditions | <input type="checkbox"/> Prostate problem     |                                            |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Psychiatric care     |                                            |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Rheumatoid Arthritis |                                            |



1180 FIR STREET CAMPBELL RIVER, BC V9W 3B8  
250-287-8487

**STRESS SURVEY**

**Please rate the following on a 10 point scale: 10 high/0 low**

- Physical STRESS level (posture, sitting, standing, lifting, twisting) /10
- Chemical STRESS level (coffee, alcohol, cigarettes, drugs, diet) /10
- Emotional STRESS level (deadlines, relationships, responsibilities) /10

**Physical Activity Level:**  Not so good  Good  Great

How many times per week do you exercise? \_\_\_\_\_

**Nutritional Intake:**  Not so good  Good  Great

Supplements: \_\_\_\_\_

**Posture:**  Not so good  Good  Great Do you wear:  Orthotics  Heel lifts   
Arch supports

**Sleep:**  Not so good  Good  Great Age of mattress: \_\_\_\_\_

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time treatments are received, unless other arrangements are made in advance.

X \_\_\_\_\_  
SIGNATURE DATE