Happy Family Wellness Clinic
Healthy family – Happy family

25-10815 Bathurst St.
Richmond Hill, ON L4C 9Y2
Tel.: 905-737-5559 Fax: 905-737-5556
www.HappyFamilyWellness.ca

PATIENT INTAKE FORM - **CHIROPRACTIC**

_____ I understand that 24 hours is required to cancel any appointments, otherwise I will be charged a $30 late cancellation/no-show fee.

Patient Name:_____ Birth Date (D/M/Y):____/___/_____

Age: _____ Gender: ☐Female ☐Male Email:_____

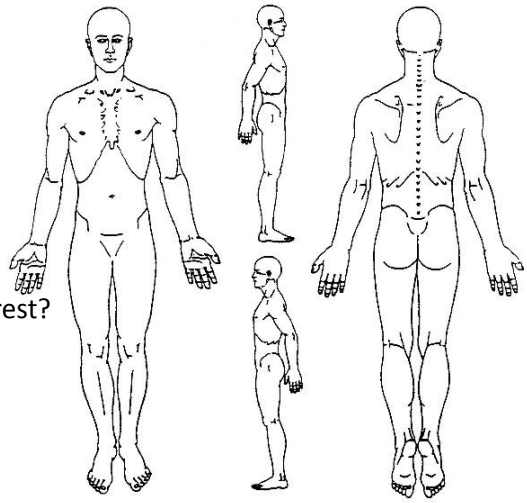
Address:_____ City:_____ Postal code:_____

Phone (Home):_____ Phone (Cell):_____

Occupation:_____ Family Doctor:_____

How did you hear about our clinic? _____ Referred By: _____

Please mark where the pain is located.



ADDRESSING THE ISSUE THAT BROUHT YOU TO OUR OFFICE

1. What is your major symptom/problem?_____
2. When did your symptoms begin?_____
3. Have you had this problem before? ☐Yes ☐No
4. Is the problem there – ☐constant ☐comes & goes ☐with use ☐at rest?
5. Is the problem getting - ☐worse ☐no change ☐better?
6. What makes it worse?_____
7. What makes it better?_____
8. How does it feel? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Stiff ☐Aching ☐Tingling ☐Throbbing ☐Swelling Other:_____
9. How would you rate the sensitivity of your pain (0=no pain, 10=severe pain)? _____
10. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation?
11. What test have you had for this condition?: ☐Spinal Exam ☐X – ray ☐MRI ☐CT Scan
12. Have you received any treatment for this condition? ☐Orthopedic ☐Physiotherapy ☐Massage Therapy ☐Acupuncture ☐Surgery (Date D/M/Y: _____) Other: _____

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Patient Health Questionnaire

Please check ( ) if any of the following apply to you. Knowledge of these conditions may influence the type of treatment you receive.

☐Anxiety/depression
☐Arthritis
☐Asthma
☐Cancer
☐Chest Pain
☐Chronic fatigue
☐Cold hands/feet
☐Diabetes
☐Digestive problems
☐Dizziness/Vertigo
☐Epilepsy
☐Falls/Head injuries
☐Headaches
☐Heart Disease
☐Herniated Disk
☐High Blood Pressure
☐Jaw Pain/TMJ
☐Pacemaker
☐Osteoporosis
☐Pain –Neck
☐Pain – Mid Back
☐Pain- Arm/Elbow
☐Pain – Hand
☐Pain – Wrist
☐Pain – Shoulder
☐Pain – Ankle or Foot
☐Pain – Leg
☐Pain – Knee
☐Allergy
☐Scoliosis
☐Stroke
☐Swelling, Stiffness of Joints
☐Tinnitus (Ear Noises)
☐Hearing, Vision loss
☐Other_____

Medications/Supplements you currently take:_____

Are you pregnant?: ☐No ☐Yes How many weeks? _____

HAVE YOU EVER:

Had an accident (car,fall,sport,other)? ☐No ☐Yes, please describe:_____

Had an operation? ☐No ☐Yes, please describe:_____

Had a fracture? ☐ No ☐Yes, please describe:_____

Been hospitalized? ☐No ☐Yes, please describe:_____

FAMILY HISTORY: Have your grandparents, parents or siblings ever been diagnosed with any of the following?

- □ High Blood Pressure
- □ Heart Stroke
- □ Stroke
- □ Diabetes (Type I or Type II)
- □ Thyroid/ Hormone Problems
- □ Breathing or lung problem
- □ Rheumatoid Arthritis
- □ Osteoarthritis
- □ Neurological problems
- □ Cancer
- □ Kidney Disease
- □ Other specifiy:_____

I certify that all the above personal health information, on page one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Print Patient Name:_____

Patient or Guardian Signature:_____ Date (D/M/Y) _____/_____/_____