Diagnostic Codes: **Date:** **File #:**

Art of Chiropractic on 12th

1238 12th Ave. S.W., Calgary, Alberta T3C-0P3 Phone: 403-228-5922 Fax: 403-228-5208 Email: info@AOCon12th.com

Initial Intake/Case History

(New patient examinations are scheduled for 45 minutes. Please fill out your intake forms prior to your appointment.)

WHY THESE FORMS ARE IMPORTANT

The purpose of collecting health information is to have a clear understanding of the patient's health concerns. This allows your health care provider to direct a patient history and physical examination leading to an accurate diagnosis. A course of treatment will be suggested if applicable. Your personal health information is sensitive and will be kept confidential at all times. Personal information will not be released to any other party without your consent.

First Name:_____ **Last Name**:_____ **Date**:_____
(dd/mm/yy)

Address: _____**City**: _____ **Postal Code**: _____ **Sex: M/F**
(circle)

Home Ph#: _____**Work Ph#**: _____ **Cell Ph#**:_____

Email: _____
(Please note email addresses are only used to send patient appointment reminders, receipts and periodic clinic updates.)

Date of Birth: _____**Age**: _____ **Alberta Health Care#**: _____
(dd/mm/yy)

Occupation: _____ **Employer**: _____ **M.D.**: _____

Insurance Provider: _____ **Policy #s:** _____

Previous Chiropractic Care? Yes/No **Chiropractor**: _____

Date of last visit: _____ **Who can we thank for your referral?**: _____
(dd/mm/yy)

Spouse:_____ **Family**:____ **Friend**:____ **M.D.**:____ **Sign**:____ **Other Chiropractor**:____ **Website**:_____

Height:____ft.____inches **Weight**: ____lbs.

Single:____ **Widowed**:____ **Divorced**:____ **Married**:____ **No. of Children**:____

In case of emergency: _____ **phone #:**_____

Please advise the Doctor if this is a Work related or Motor Vehicle Accident related injury.

Patient Name: **Date :** **File #:**

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

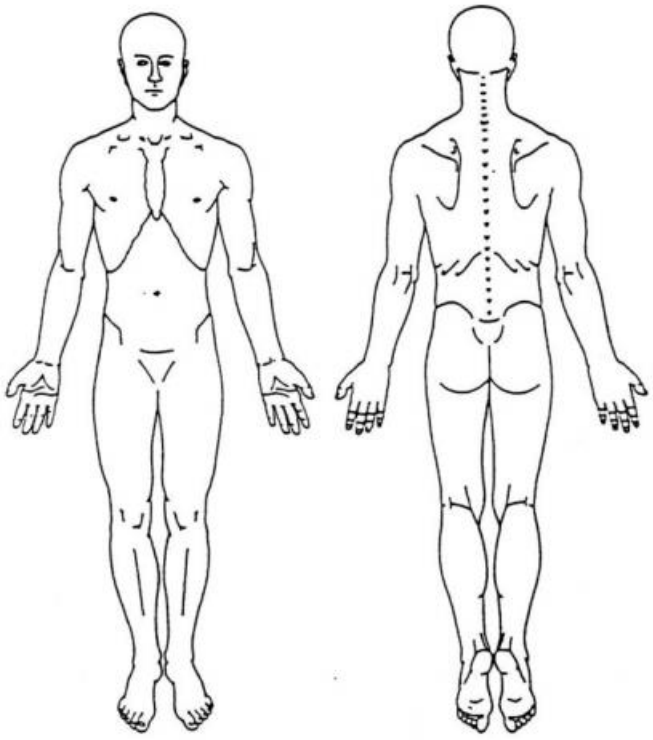
I am seeking care for : _____

☐ Headaches /10 ☐ Neck Pain/Stiffness /10 ☐ Whiplash (Sprain/Strain) /10 ☐ Chest Pain /10
☐ Midback Pain /10 ☐ Lower Back Pain /10 ☐ Rib Pain /10 ☐ Leg/Arm Pain /10 ☐ Wellness care

Previous treatment (circle) : manual or instrument adjustment / active release / laser therapy / MD / PT / Massage

Location of complaint: _____

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Date of Onset:_____ **Mode of onset:**_____
Have you experienced this pain before? No / Yes If Yes, When? _____
Description of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Throbbing ☐ Nagging ☐ other_____
Rate the pain on a scale of 0-10 with 10 being the worst pain ever: 0 1 2 3 4 5 6 7 8 9 10 (severity)
Fx of pain: ☐Occasional (0-25% of time awake) ☐ Intermittent (25-50%)☐ Frequent (50-75%) ☐Constant (75-100%)
Is there any associated radiation of pain or weakness? _____
Do you have any numbness or tingling? _____
Since the problem started, it is… ☐ About the same ☐ Getting Better ☐ Getting Worse
What makes this condition better?_____
What makes this condition worse?_____
Doctor Notes:

_____
_____
_____
_____
_____
_____

Other Health Care Professionals seen for this problem and treatment provided (please list):

☐ **Chiropractor, Acupuncture, Massage** _____

☐ **Medical Doctor** _____

☐ **Other** _____

Have you had previous X-rays/CT scan/MRI? _____**When?** _____**Where?**_____

Please check (✓) all symptoms that you are experiencing even if they seem unrelated to your problem area:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Loss of smell	☐ Pins and needles in arms	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff neck	☐ Erectile dysfunction	☐ Cold hands/feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Bowel/Bladder dysfunction	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Genitalia numbness

Have you been under drug and medical care? Yes / No explain:_____

_____

What medications are you taking? _____

How Long? _____ **Have you had surgery?** _____ **What?** _____ **When?** _____

Is there a familial history of:	**Heart Disease**	**Stroke**	**Arthritis**	**Cancer**	**Diabetes**	**Other**_____
Father's Side	☐	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐	☐

Previous Health History

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following question to the best of your ability.

YOUR CHILDHOOD YEARS	YES	NO	UNSURE	Pt Comments:	Dr. Comments
Did you have any childhood illnesses?	☐	☐	☐	_____	_____
Did you have any serious falls as a child?	☐	☐	☐	_____	_____
Did you play youth sports?	☐	☐	☐	_____	_____
Did you take/use any drugs?	☐	☐	☐	_____	_____
Did you have any surgery?	☐	☐	☐	_____	_____
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐	_____	_____
Were you involved in any car accidents as a child?	☐	☐	☐	_____	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	_____	_____
Did you suffer any other traumas (physical or emotional)?	☐	☐	☐	_____	_____
Were you vaccinated?	☐	☐	☐	_____	_____
As a child, were you under regular Chiropractic care?	☐	☐	☐	_____	_____

Patient Name: **Date :** **File #:**

Adult – (18 to present)

				Pt Comments:	Dr. Comments
Were you taught proper body movement?	☐	☐	☐	_____	_____
Do/ did you smoke?	☐	☐	☐	_____	_____
Do/ did you drink alcohol?	☐	☐	☐	_____	_____
Diet (Do you eat healthy foods?)	☐	☐	☐	_____	_____
Have you been in any accidents?	☐	☐	☐	_____	_____
Have you had surgery/organs removed?	☐	☐	☐	_____	_____
Drugs? (Prescription/non prescription)	☐	☐	☐	_____	_____
Teeth/Eye/Hearing problems?	☐	☐	☐	_____	_____
Do you exercise regularly?	☐	☐	☐	_____	_____
Sleeping habits (nightmares?)	☐	☐	☐	_____	_____
Do/ did you have occupational stress?	☐	☐	☐	_____	_____
Physical Stress?	☐	☐	☐	_____	_____
Mental Stress?	☐	☐	☐	_____	_____
Do/ did you participate in sports?	☐	☐	☐	_____	_____
Have you had any sport related injuries?	☐	☐	☐	_____	_____

Health Profile:

How many cups (8 oz.) of water do you drink in a day? _____ Coffee? _____ Caffinated tea? _____

Do you feel rested when you wake up in the morning? _____ Do you feel stiff and sore in the morning?_____

What position do you sleep in? ☐ Front ☐ Back ☐ Side How many pillows do you sleep with? _____

I acknowledge that I have read the intake forms and that the statements made on the intake form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature of Patient_____ ***Date***_____

Name (Print Please) _____

ART of Chiropractic on 12th Financial Policy

Please be advised that we do have the ability to direct bill some insurance companies however it does not always mean you are covered in full. Our office staff will always do their best to help you process claims directly if possible; however if a claim is not fully covered or is rejected the patient will ultimately be responsible for any outstanding amounts. If no insurance is available payment is due at time of services rendered.

I understand the AOC on 12th Financial Policy and authorize AOC on 12th to bill (electronically) when possible on my behalf:

Signature of Patient_____ ***Date***_____

Name (Print Please) _____