PATIENT INTAKE FORM

HARMONY
CHIROPRACTIC

MB Health # (6 Digits): _____ PHIN # (9 Digits): _____
Full Name: _____ Gender: _____
Date of Birth (MM/DD/YYYY): _____
Address: _____ Postal Code: _____
City/Province: _____ Phone Number: (Home) _____
(Work) _____ (Cell) _____
Email: _____ May we add you to our e-mail list? **Yes / No**
Occupation: _____ Employer & Address: _____
Emergency Contact: _____ Relation: _____ Phone: _____
Marital Status: **S / M / D / W / Other** Significant Other's Name: _____
# of children: _____ How did you hear about us? _____

Have you had previous chiropractic care? **Yes / No** Chiropractor: _____
Result of past care: **Excellent / Good / Fair / Poor** Last Visit: _____
Who is your medical doctor: _____ Date of Last Physical: _____
Do you smoke: **Yes / No** Consume Alcohol: **Yes / No**
Please list all medications, supplements: _____
How often do you exercise? _____ Type of exercise: _____
Common activities at work: **Sitting / Standing / Walking / Bending / Other**

Please list your primary reason for seeking care at Harmony Chiropractic: _____
_____
How long have you had this? _____ It is getting: **Better / Worse / Not Changing**
Have you had this in the past? _____
This interferes with: **Work / Sleep / Exercise / Daily Activity / Other**
What other treatment have you had for this condition? _____
Have you missed work or school because of this condition? _____
On a scale from 0 (no pain) to 10 (worst pain imaginable), please rate your discomfort:

0 1 2 3 4 5 6 7 8 9 10

Are there any other conditions/concerns you would also like to seek care for? _____
_____
How long have you had this? _____ It is getting: **Better / Worse / Not Changing**
Have you had this in the past? _____
This interferes with: **Work / Sleep / Exercise / Daily Activity / Other**
What other treatment have you had for this condition? _____
Have you missed work or school because of this condition? _____
On a scale from 0 (no pain) to 10 (worst pain imaginable), please rate your discomfort:

0 1 2 3 4 5 6 7 8 9 10

HARMONY CHIROPRACTIC

PATIENT HEALTH HISTORY

Please indicate if you have had or currently have any of the following conditions:

CURRENT	PAST	MUSCULOSKELETAL
☐	☐	Osteoporosis
☐	☐	Osteoarthritis
☐	☐	Joint Stiffness
☐	☐	Backache
☐	☐	Neck Pain
☐	☐	Muscle Weakness
☐	☐	Gout
☐	☐	Broken Bones
☐	☐	Joints Replaced

CURRENT	PAST	NEUROLOGICAL & MENTAL HEALTH
☐	☐	Headaches
☐	☐	Seizures
☐	☐	Numbness/Weakness
☐	☐	Concussion
☐	☐	Anxiety
☐	☐	Depression

CURRENT	PAST	CARDIOVASCULAR
☐	☐	Fainting
☐	☐	Heart Disease
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Irregular Heartbeat
☐	☐	Phlebitis
☐	☐	Poor Circulation
☐	☐	Swelling of Hands/Feet
☐	☐	Swelling of Legs

CURRENT	PAST	GASTROINTESTINAL
☐	☐	Nausea/Vomiting
☐	☐	Indigestion
☐	☐	Heartburn
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Ulcers
☐	☐	Hernia
☐	☐	Black/Bloody Stools
☐	☐	Liver Problems
☐	☐	Gallbladder Problems
☐	☐	Bowel Problems
☐	☐	Hemorrhoids

CURRENT	PAST	GENITOURINARY
☐	☐	Frequent Infections
☐	☐	Urination Problems
☐	☐	Blood in Urine
☐	☐	Kidney Disease
☐	☐	Kidney Stones
☐	☐	Prostate Problem

CURRENT	PAST	RESPIRATORY
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Cough/Wheezing
☐	☐	Emphysema
☐	☐	Difficulty Breathing
☐	☐	Pneumonia
☐	☐	Shortness of Breath

CURRENT	PAST	EYES/EARS/NOSE/THROAT
☐	☐	Dizziness
☐	☐	Hearing Problems
☐	☐	Vision Problems
☐	☐	Double Vision
☐	☐	Blurry Vision
☐	☐	Sinus Infection
☐	☐	Jaw Clicks
☐	☐	Bleeding Gums
☐	☐	Difficulty Swallowing
☐	☐	Frequent Colds
☐	☐	Allergies
☐	☐	
☐	☐	

CURRENT	PAST	FEMALES
☐	☐	Irregular Cycle
☐	☐	Painful Menstruation
☐	☐	Excessive Flow
☐	☐	Menopause
☐	☐	Hot Flashes
☐	☐	Miscarriage

Are you pregnant? **Yes / No** If yes, when is your due date? _____

Other: _____

_____

_____

Do you or have you ever had any of the following conditions? Please Circle.

Aneurysm Cancer Stroke Diabetes Heart Attack Fatigue Sleeping Difficulty

Other: _____

Do you have a family history of any of the following?

Cancer Diabetes Heart Attack Stroke Other: _____

Please list any surgeries and/or serious injuries: _____

Please list any allergies: _____

Is there anything else your provider should know regarding your health? _____

_____

The personal health information you provide us will be kept confidential and secure and only used by the practitioners and staff at Harmony Chiropractic. However, limited information, such as date of service, may be requested and collected on occasion by your insurance provider. I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, and that if I suspend or terminate my care, any outstanding charges for services rendered to me will be immediately due.

Name: _____

Signature of patient/guardian: _____ Date: _____