PATIENT INTAKE FORM

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: ____ Occupation: ___________________________

Employer: ____

Emergency Contact: ________________________ Relation: ______________ Phone: _____________

Marital Status: ☐S / ☐M / ☐D / ☐W / ☐Other Significant Other's Name: ______________________

# of children: ___________

Have you had previous chiropractic care? ☐Yes / ☐No

Result of past care: ☐Excellent / ☐Good / ☐Fair / ☐Poor Last Visit: ___________________________

Who is your medical doctor: ___________________________ Date of Last Physical: ________________

Please list all medications, supplements: ____

How often do you exercise? ________________ Type of exercise: ______________________________

Common activities at work: ☐Sitting / ☐Standing / ☐Walking / ☐Bending / ☐Other ______________

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Please list your primary reason for seeking care at Harmony Chiropractic: _____________________

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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: ____________

Are there any other conditions/concerns you would also like to seek care for? __________________

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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
☐	☐	Muscle Weakness
☐	☐	Gout
☐	☐	Broken Bones
☐	☐	Joints Replaced

CURRENT	PAST	GASTROINTESTINAL
☐	☐	Indigestion
☐	☐	Heartburn
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Ulcers
☐	☐	Hernia
☐	☐	Bowel Problems
☐	☐	Hemorrhoids

CURRENT	PAST	EYES/EARS/NOSE/THROAT
☐	☐	Dizziness
☐	☐	Hearing Problems
☐	☐	Double or Blurry Vision
☐	☐	Sinus Infection
☐	☐	Jaw Pain or Clicking
☐	☐	Difficulty Swallowing

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

CURRENT	PAST	RESPIRATORY
☐	☐	Asthma
☐	☐	Cough/Wheezing
☐	☐	Emphysema
☐	☐	Difficult or Painful Breathing
☐	☐	Shortness of Breath

CURRENT	PAST	GENITOURINARY
☐	☐	Frequent Infections
☐	☐	Urination Problems
☐	☐	Kidney Stones
☐	☐	Prostate Problems

CURRENT	PAST	FEMALES
☐	☐	Irregular Cycle
☐	☐	Painful Menstruation
☐	☐	Excessive Flow
☐	☐	Menopause

Are you pregnant? ☐ Yes ☐ No
If yes, when is your due date?

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

Other: ______________________________

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

☐ Aneurysm ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Heart Attack ☐ Other: ______________________________

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

☐ Cancer ☐ Stroke ☐ Diabetes ☐ Heart Attack ☐ Other: ______________________________

Please list any surgeries and/or serious injuries: ______________________________

Is there anything else you would like your provider to know? ______________________________

How did you hear about us? ______________________________

May we add you to our e-mail list? ☐ Yes / ☐ No

The insurance and personal information you provide us will be kept confidential and secure and only used by 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 and consent to release of this information as necessary.

Harmony Chiropractic offers the service of direct billing to its patients and clients. If direct billing is not available, or no coverage exists or remains for the services rendered, outstanding fees will be charged directly to the patient. I understand and agree that I am personally responsible for this payment, and that any outstanding charges for services rendered to me will be immediately due.

Name: ______________________________

Signature of patient/guardian: ______________________________ Date: ______________