



ADULT INTAKE - Chiropractic

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (home): _____ (work): _____ (cell): _____

Email address: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone: _____

Occupation: _____ Hours per week: _____

Employer: _____

How did you hear about this clinic? _____

If internet: Google: ___ CAND Website: ___ OAND Website: ___ Other: _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?



Health Status Survey

Please circle any conditions or symptoms presently causing you problems.

General Symptoms

- Loss of consciousness
- Blackouts
- Headaches
- Dizziness
- Clumsiness
- Convulsions
- Loss of sleep
- Numbness, pain or tingling in your limbs
- Nervousness
- Loss of weight
- Fever
- Night pain

Muscle and Joints

- Stiff neck
- Back ache
- Swollen joints
- Painful tailbone
- Foot problems
- Shoulder pain
- Arm/Forearm pain
- Elbow pain
- Wrist pain
- Hand pain
- Arthritis
- Weakness or loss of strength

E.E.N.T

- Blurred vision
- Failing vision
- Crossed eyes
- Double vision
- Eye pain
- Deafness
- Earache
- ringing, buzzing in ears
- Asthma
- Frequent colds
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Slurred speech
- Difficulty swallowing

Respiratory

- Chronic cough
- Phlegm production
- Coughing up blood
- Chest pain
- Difficulty breathing

Cardiovascular

- Bleeding disorder
- High blood pressure
- Pain over heart
- Stroke
- Hardening of arteries
- Varicose veins
- Swelling of ankles
- Poor circulation
- Angina

Genitourinary

- Trouble urinating
- Blood in urine
- Kidney infection
- Bed wetting
- Prostate troubles

For Women

- Painful menstruation
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps
- Vaginal discharge
- Swollen/Painful breast
- Lumps in breasts

Skin

- Rashes
- Itchy
- Bruise easily
- Dryness
- Boils
- Hives
- Warts

Gastrointestinal

- Poor appetite
- Indigestion
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Pain over stomach
- Constipation
- Diarrhea
- Hemorrhoids
- Jaundice
- Gall bladder trouble
- Intestinal worms
- Ulcer

Do you have Diabetes? Yes/ No

Have you been diagnosed with Cancer? Yes/ No

Have you had any fractures? Yes/ No

Have you been in a car accident? Yes/ No

Are you currently taking birth control? Yes/ No

Do you Smoke? Yes/ No

What medication do you currently take?

Pain Diagram

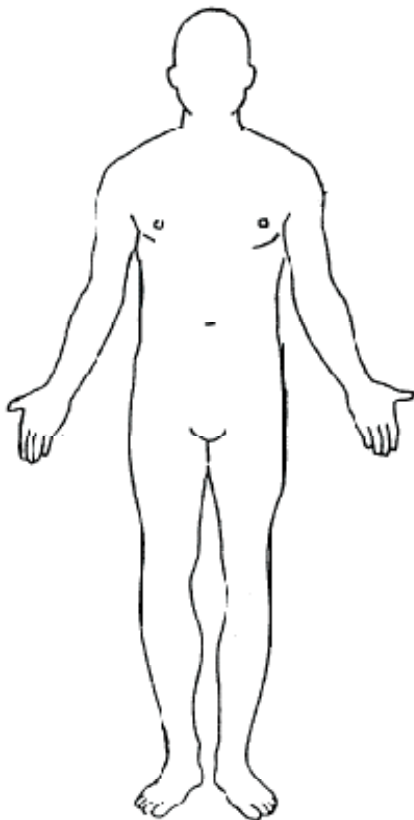
Patient Name: _____

Date: _____

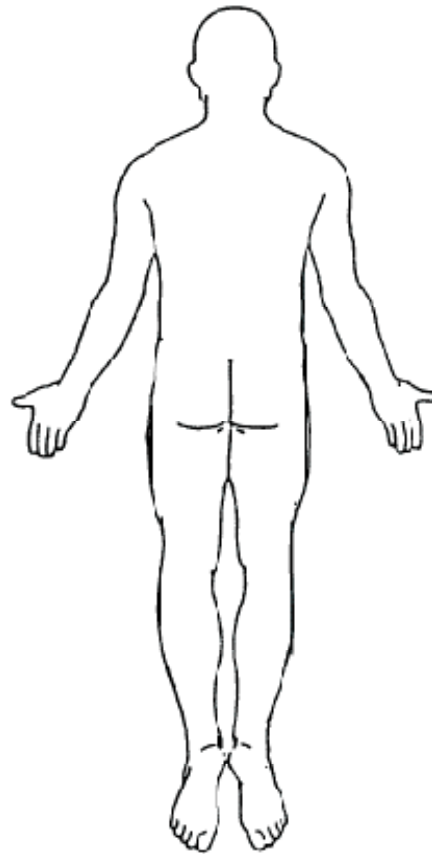
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Just to complete the picture, draw in your face.

Front



Back



Numbness
|| || ||

Pins and Needles
o o o o o

Burning
x x x x x

Stabbing
/// ///

Ache
^ ^ ^ ^

Comments:



Consent for Relay of Medical Information- Privacy Code

Employees and practitioners of this office must have your permission to relay your medical information on the phone. We do however understand the importance of protecting your personal information. We will comply with legal and regulatory requirements under the Regulated Health Professionals Act. The use, retention, and destruction of your personal information complies with privacy legislation, standards of our regulatory bodies, and the law. Only necessary information is collected about you. Exchange of medical information collected is important to deliver safe and effective care, to communicate with other health care providers, and to process payments.

Please let us know how you would like to be contacted. If you do not give us specific permission to speak to your family members we will assume that you do not want any information relayed to anyone in your household other than yourself.

Please *circle* which ways we may communicate with you:

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Please specify the names of people who you authorize this office to discuss your care with:

May we leave messages on your home answering machine? **Yes or No**

May we leave messages on your cell phone voice mail? **Yes or No**

May we leave messages on your work voice mail? **Yes or No**

With this consent, I give Kilborn Naturopathic & Wellness Centre permission to call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Kilborn Naturopathic & Wellness Centre may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and health care operations, such as newsletters, clinic events, and patient statements.

With this consent, Kilborn Naturopathic & Wellness Centre may send an e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, newsletters, clinic events, and patient statements.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient's Name (please print)

Signature

Parent/Guardian Signature if applicable

Date



Patient Authorization Form for Exchange of Medical Information

TO: Physician: _____

Address: _____

Phone Number: _____

Fax Number: _____

RE: Patient Name: _____

OHIP number: _____

D.O.B: _____

I understand that I may refuse to sign this form, and that my chiropractic care will not be affected if I do not sign this form. Please initial: _____

I hereby direct and authorize you to exchange my medical file and information with Dr. Melanie Stewart, at the Kilborn Naturopathic & Wellness Centre.

Signature/Guardian signature

Date

Patient