CHIROPRACTIC INTAKE FORM Dr. Amanda Lett, BSc(Hons), DC

PATIENT INFORMATION

Name: _____ Sex: Male Female

Date of Birth: mm/dd/yyyy ____/____/_____ Age:_____

Address: _____ City: _____Postal Code:_____

Phone: (Home) _____(Cell)_____

May we leave you a message at either number? YES NO Email address: _____

How did you find out about us? _____

Occupation: _____ Marital Status:_____

Emergency Contact: (Name) _____(Relationship) _____ (Phone number) _____

Fee Schedule

Initial assessment: $110 | Subsequent visit: $55 | Re-Assessment: $ 80 | Custom Orthotics: $450

Payment is due at the time services are rendered.

A deposit is required prior to ordering custom-made orthotics.

Cancellation/ No show policy:

We require **24 hours notice** if you are unable to make your scheduled appointment. Without providing such notice, or in the case of a no-show, please be aware that you will be charged the full amount as a Missed Appointment fee.

I have read and understand the financial policy. I agree to pay any and all charges incurred for services rendered and/or items purchased at Miltowne Physiotherapy.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

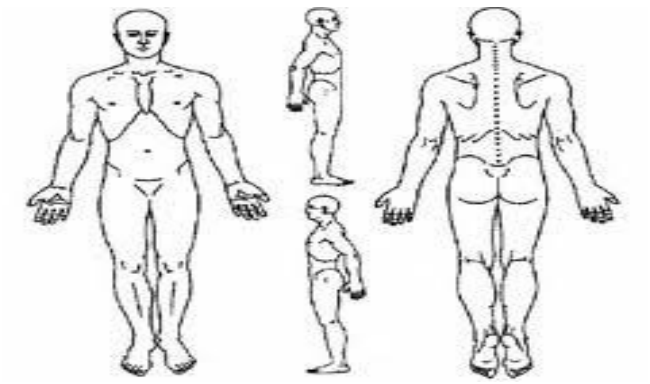
PATIENT HEALTH QUESTIONNAIRE

Patient name: _____ **Date:**_____

1. What are you being seen for today?:_____

When did your symptoms begin?:_____

Please indicate on the provided diagram the location of your complaint



Please indicate a number on the scale below to tell us how intense your pain is:

No pain **Moderate** **Unbearable**

|---------- |----------|

0 1 2 3 4 5 6 7 8 9 10

2. How often do you experience your symptoms?

☐ Constantly (76-100% OF THE DAY)

☐ Occasionally (26-50% OF THE DAY)

☐ Frequently (51-75% OF THE DAY)

☐ Intermittently (0-25% OF THE DAY)

3. What describes the nature of your symptoms?

☐ Sharp

☐ Burning

☐ Shooting

☐ Numb

☐ Dull ache

☐ Tingling

4. How are your symptoms changing?

☐ Getting better

☐ Not changing

☐ Getting worse

5. Activities that make symptoms worse: _____

6. Activities that make symptoms better: _____

7 Who have you seen for your symptoms?

☐ No one

☐ Physiotherapist

☐ Medical doctor

☐ Other _____

☐ Chiropractor

When and what treatment?_____

Patient name: _____ **Date:**_____

9. Have you had similar symptoms in the past? ☐ YES ☐ NO

If yes, who did you see?
☐ Medical doctor ☐ Physiotherapist
☐ Chiropractor ☐ Other _____

Please indicate if you have had any of the following conditions, past or present:

Past	Present		Past	Present		Past	Present	
☐	☐	Abdominal pain	☐	☐	Cancer	☐	☐	Diabetes
☐	☐	Ulcer	☐	☐	Thyroid disorder	☐	☐	Excessive thirst
☐	☐	Hepatitis				☐	☐	Frequent urination
☐	☐	Liver/ gallbladder disorder	☐	☐	Abnormal weight gain/ loss			
			☐	☐	Loss of appetite	☐	☐	Joint swelling
						☐	☐	Arthritis
☐	☐	Blurred or double vision	☐	☐	Kidney stones	☐	☐	General fatigue
☐	☐	Dizziness	☐	☐	Kidney disorders			
☐	☐	Muscle incoordination	☐	☐	Bladder infection	☐	☐	Osteoporosis
			☐	☐	Painful urination			
☐	☐	Blood clots	☐	☐	Loss of bladder control			**List any other health problems:**
			☐	☐	Prostate problems			
☐	☐	High blood pressure						
☐	☐	Heart attack						
☐	☐	Chest pain	☐	☐	Systemic lupus			
☐	☐	Stroke	☐	☐	Epilepisy			
☐	☐	Angina	☐	☐	Depression			
								FEMALES ONLY
						☐	☐	Pregnancy
						☐	☐	Birth Control Pills
						☐	☐	Hormone replacement therapy

Patient name: _____ **Date:**_____

INDICATE IF AN IMMEDIATE FAMILY MEMBER (PARENT OR SIBLING) HAS HAD ANY OF THE FOLLOWING:

☐ Rheumatoid Arthritis ☐ Cancer

☐ Heart problems ☐ Stroke

☐ Diabetes ☐ Other _____

List all prescription and over-the-counter medications you are taking:

_____

_____

List all surgical procedures you have had and any times of hospitalization:

_____

_____

Are you a Smoker? ☐Yes ☐No

If yes, How many years and how many / day_____

What is your height and weight? Height: _____ _____ Weight: _____ LBS.
Feet Inches

Do you wear orthotics? ☐YES ☐NO **Are you interested in custom made orthotics?** ☐YES ☐NO

ADDITIONAL COMMENTS

_____

_____

_____

_____

PATIENT SIGNATURE: _____ **DATE:**_____