NOTTINGHILL FAMILY WELLNESS CENTRE

905-827-4197 www.glenabbeychiro.com

CHIRO INTAKE FORM

Name	**Age**	**D.O.B** DD_____ MM_____ YY_____	**Sex:** Male ☐ Female ☐
Address	**City**	**Postal Code**	
Email Address	**Medical Doctors Name**		
Cell Phone ( )	**Would you like:** Text Reminder ☐ OR E-mail Reminder ☐	**Who can we thank for referring you?** Google ☐ Physician ☐ Other ☐ _____	
Occupation:	**Employer:**	**Have you had chiropractic care before?** YES ☐ NO ☐	
Emergency Contact NAME:	NUMBER:		

Private Insurance Info: or N/A ☐

INSURANCE COMPANY: _____

POLICY/GROUP #: _____

CERTIFICATE/ID #:_____

POLICY HOLDER NAME: _____

D.O.B DD_____ **MM**_____ **YY**_____

YOUR RELATIONSHIP TO POLICY HOLDER:
SELF / SPOUSE / CHILD

Please indicate any recent slips, falls or motor vehicle accidents: or N/A ☐

Date ( ) _____ Date ( ) _____

Did any of these accidents occur while you were working? YES ☐ NO ☐

Present Complaint/Pain:

Injury: _____

When did it start?_____

Is the condition getting worse? ☐ Yes ☐ No

Home Remedies? ☐ Yes ☐ No _____

Current **medications**: _____

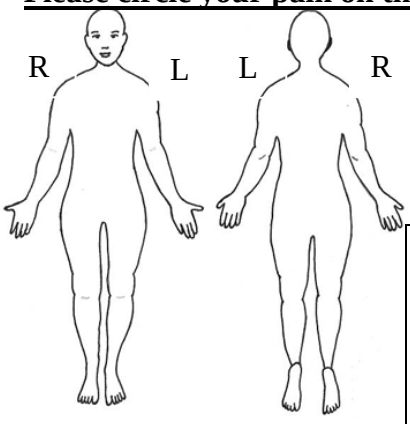
_____

Circle your current level of pain:

(10 = most severe and 1 = least painful)

1	2	3	4	5	6	7	8	9	10

Please circle your pain on the diagram and use the legend:



Legend:

+ + + Pain (dull) - - - Pain (sharp) P P P Pressure

Numbness * * * Tingling (referral) C C C Cramping

For Women:

Are you pregnant?
YES ☐ NO ☐

☐ Headaches	☐ Ringing in ears	☐ Fatigue	☐ Cold feet/hands
☐ Neck pain/stiffness	☐ Loss of taste/smell	☐ Depression	☐ Diarrhea/Constipation
☐ Sleeping problems	☐ Pins/Needles in Legs	☐ Menstrual problems	☐ Allergies/Asthma
☐ Back pain	☐ Numbness in fingers	☐ Loss of balance	☐ Significant weight loss
☐ Nervousness	☐ Numbness in toes	☐ Stroke	☐ Night Sweats
☐ Chest pains	☐ Shortness of breath	☐ Fainting	☐ Fever
☐ Dizziness	☐ Pins/Needles in Arm	☐ Foot Pain	

Patient Fee Schedule:

New Patient Exam ..... $95.00 Reassessment Exam ..... $85.00 Chiropractic Treatment $65.00

**** all prices subject to change without notice**

I, _____, consent to the fee schedule and a physical examination by the chiropractor.

Print Name

Patient Signature _____ **Date** _____