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 ☐
*If your policy allows

PLEASE NOTE ANY MODALITIES SUCH AS ACUPUNTURE, SHOCKWAVE, IFC, ETC. ARE PREFORMED BY A CHIRO AND THEREFORE ONLY BILLABLE TO CHIROPACTOR SECTION OF INSURANCE PLANS. PLEASE ASK THE FRONT DESK ANY BILLING RELATED QUESTIONS

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 ☐

A. Present Complaint/Pain:

Injury: ____

When did it start?__________________________________

Is the condition getting worse? ☐ Yes ☐ No

Home Remedies? ☐ Yes ☐ No ____________________

Current **medications**: ____

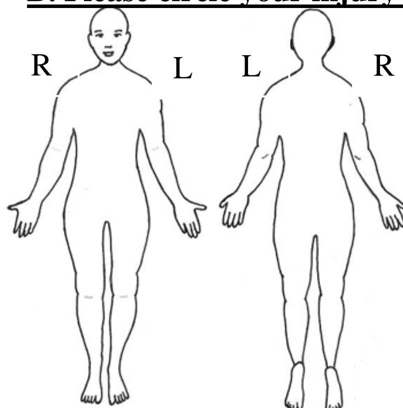
____

Circle your current level of pain:

(10 = most severe and 1 = least painful)

1	2	3	4	5	6	7	8	9	10

B. Please circle your injury on the diagram and use the 'Pain Legend':



Pain Legend: (please place on diagram)
+ + + Pain (dull) - - - Pain (sharp) P P P Pressure
# # # Numbness * * * Tingling (referral) C C C Cramping

For Women:
Are you pregnant?
YES ☐ NO ☐

C. Please indicate all relevant symptoms:

☐ Headaches	☐ Ringing in ears	☐ Fatigue	☐ Cold feet/hands
☐ Neck pain/stiffness	☐ Loss of taste/smell	☐ Depression	☐ Diarrhea/Constipation
☐ Sleeping problems	☐ Pins/Needles in Legs	☐ Fever	☐ 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	☐ Menstrual problems
☐ Dizziness	☐ Pins/Needles in Arms	☐ Foot Pain	

Patient Fee Schedule:
New Patient Exam .... $100.00 Reassessment Exam .... $85.00 Chiropractic Treatment.....$70.00

** all prices subject to change without notice

I consent to the fee schedule, direct billing policies, and a physical examination by the chiropractor by signing below.

Patient Signature ____ **Date** __________________