ADULT INTAKE FORM

Welcome to our office!

Lakeshore Family Chiropractic
Box 1131 (2-40 Centre Street)
Gimli, MB R0C 1B0
Phone: 1 (204) 642-4842

To ensure your visit is a pleasant one, here are the procedures you can expect during your first 30-minute visit:

Paperwork Complete the questionnaire and your health history to help us to get to know you better. We will use this information to help formulate recommendations for your care. Read and sign the informed-consent form.

Consultation Doctor Roch will review your history to see if your situation is a chiropractic case. He will advise you of the cost of all office procedures in advance.

Examination He will perform standard physical, orthopedic, neurological, and chiropractic tests to determine the cause(s) of your difficulties.

Images He will refer you to the appropriate x-ray specialist if x-rays or scans are needed. These will help reveal the location of any spinal problems, neurological interferences, or any pathology, to make your chiropractic care more precise.

Correlation Doctor Roch will study your examination findings, and at your next visit will review them with you, and give you specific care and recommendations for a healthy future.

Confidential Patient Case History **GENERAL INFORMATION**

Name: ____ Date: ____________

Address: ____ City: _______________ Postal Code: ____________

E-mail: ____________________ Birth Date (Yr/Mo/Day) ________________________ Age: __________________

MHSC # (6 digit) ______________ (9 digit) ______________MPI/WCB# ___________________ Accident Date: ______________

Home Phone: ______________ Work Phone: _______________ Ext: ____ Cell/Other: _________________

Occupation or Profession: ________________________ Work Address: ____

Employed by: ____ _____ Part-Time _____ Full-time _____ Retired

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Number of Children: _____ Names: ____

Name of Medical Doctor: __________________________ Phone Number: ____

What is the **major complaint** for which you are seeking Chiropractic care?: ____

Who referred you to us? ____

Insurance Coverage:
Name of Insurer (Plan #1): _________________________________ Plan #1 Contract Number: _______________

Is this your plan, or your spouse’s plan? ______________________________ Amount of Coverage: ___________________ %

Name of Insurer (Plan #2): _________________________________ Plan #2 Contract Number: _______________

Is this your plan, or your spouse’s plan? ______________________________ Amount of Coverage: ___________________ %

We accept payment by cash or cheque.

I understand that I must pay all services **in full at the time of service**, unless other arrangements have been made and agreed upon in writing.

Signature: _________________________________ **Date**: ___________________

Thank you. We look forward to a healthy relationship with you!

Please Describe Your Health Concerns

1. What are the major problems you are experiencing? ____

   ____

2. If this is a reoccurrence, when did you originally notice the problem?__________________________________

   What initially caused it?____

3. Has it changed recently? ___ Better ___ Worse ___ Same   What types of treatment have you tried?

   ____

   What makes it better? ____

   Worse? ____

4. How frequent is the condition? __________________ How long does it last? _________________________

5. Is this affecting your sleep? ___ Yes ___ No   If yes, please describe: ______________________________

   ____

6. Is this affecting your ability to perform your job or daily activities? ___ Yes ___ No   If yes,

   please describe: ____

7. Are there other symptoms that you have not listed that may be related to these concerns?

   ___ Yes ___ No   If yes, please describe: ____

8. Is the condition due to injury or sickness arising out of employment? _________________________________

9. Is the condition due to injury or sickness arising out of an auto or other type of accident? _______________

10. Number of days lost from work ______ Date symptoms appeared or accident happened ________________

11. Please list all doctors you have seen related to your current concern.

    a. ______________________________________   b. __________________________________

    c. ______________________________________   d. __________________________________

12. Please list any medications you have taken in the past year.

    a. ______________________________________   b. __________________________________

    c. ______________________________________   d. __________________________________

Please mark an "X" on the line to indicate the severity of your condition:

No Symptoms   Extreme Symptoms
Does not interfere with activities   Disabling
(   )--(   )--(   )
<<<<<<<<<<>>>>>>>>>

Please mark any areas of concern on the diagrams below. N – numbness   P – pins & needles
B – burning   A – aching   S – stabbing. Indicate any other problems as best you can.

Survey of Your Health History

Please circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.

1. General
Fever
night sweats
nervousness/anxiety
bleeding
diabetes
thyroid
headache
fainting
depression
memory loss
chills
fatigue: AM/after lunch/ PM
weight loss/gain
anemia
cancer
substance abuse
dizziness
seizures
phobias
waking in night
problems falling asleep
hospitalizations:_______________
____
____
any broken bones, car accidents or other injuries? ________________
____

2. Gastrointestinal
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other _________________________

3. Respiratory
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other _________________

4. Cardiovascular
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other _________________

5. Musculoskeletal
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other _________________

6. Skin
rashes
mole changes
itching
nail changes
redness
other __________________

7. EENT
blurry vision
double vision
eye pain
jaw pain
ringing in ears
ear infection
sinus problems
nose bleeds
throat problems
speech problems
glasses or contacts? _____

8. Genitourinary
frequent/painful urination
incontinence
blood in urine or stool
urinary infection
venereal infection
other ________________

9. Women Only
difficult periods
hot flashes
irregular cycles
breast pain
difficulty becoming pregnant
complication of pregnancy
other _________________
Date last period ended _____
Period begins every ____ days
Date of last gynecologic exam
____

10. Men Only
testicular pain
prostate problems
difficult erection
low sperm count

11. Endocrine
heat/cold intolerant
sugar cravings
weight gain in abdomen
problems with missing a meal
better after meal
thyroid problems

12. Habits
water (____ cups/day)
smoke (___packs/day, years)
alcohol (___ drinks/week)
caffeine (___ cups/day)
recreational drug use _______

13. Family
Are your parents living? _____
If so do you consider them to be in good health? ____________
ages: Mother ___ Father ___

Circle any below that apply to your parents, siblings or children: diabetes stroke hypertension cancer seizures tremors brain disorders heart disease lung disease arthritis scoliosis thyroid

Signature:____ **Date:** _______________