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 _____

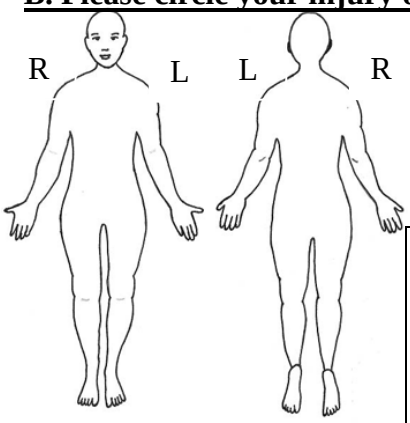
Current **medications**: _____

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:

Assessment ..... $130.00 Re-Assessment Exam ..... $95.00 **** all prices subject to change without notice**

Chiropractic Treatment.....$75.00 Chiropractic Treatment with Acupuncture …..$85.00

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

Patient Signature _____ **Date** _____