Profile Information

You are filling out an intake form for

_____

First & Last Name

Please take a moment to fill out our online **Chiropractic Intake Form (Adult)** before your visit. All information is kept completely confidential.

Email – *Required*

Preferred Name (if different)

Prefix / Title

Pronouns

Please provide at least one phone number. Your mobile number can be used to look up your Account.

Home Phone

Mobile Phone

A mobile phone is required if you would like to receive SMS appointment reminders.

Street Address – *Required*

Suite Number

City – *Required*

Province – *Required*

Postal / Zip – *Required*

Date of Birth – *Required*

Month

Day

Year

Gender – *Required*

Sex – *Required*

Personal Health Number – *Required*

Occupation

Employer

Guardian

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of Referring Professional

Referring Professional Phone or Email (if known)

Credit Card Information

Add a credit card

Gulf Islands Chiropractic strongly recommends that you put a card on file for contactless payments. This helps keep both you and us safe, as well as spend more time with you, rather than taking a payment after your session.

Card number

Expiration date

☐ **I am aware of the Cancellation Policy.**

Questionnaires

Please list and rank your top three health concerns or chief complaints in order of importance (1 being the most important):

Health Concern #1 (most important):

Health Concern #2

Health Concern #3

Please focus on your #1 concern (most important) for the following questions:

When did it start?*

Have you had this issue before?*

- [ ] Yes
- [ ] No

What do you think caused this issue?*

Were you injured at work or in a car accident? (If so, please describe the incident)

How frequently does the issue occur?*

- [ ] Comes and goes
- [ ] Constant
- [ ] Only triggered by aggravating factors
- [ ] Getting better
- [ ] Getting worse

Rate your pain or discomfort on a scale from 0 to 10

0 - Being in no pain or discomfort | 1 | 2 - Mild pain or discomfort | 3 | 4 | 5 - Moderate pain or discomfort | 6 | 7 | 8 - Severe pain or discomfort | 9 | 10 - Highest level of pain or discomfort experienced

Pain or discomfort description*

- [ ] Aching
- [ ] Burning
- [ ] Dull
- [ ] Sharp
- [ ] Stabbing
- [ ] Throbbing
- [ ] Weakness
- [ ] Numbness/tingling
- [ ] Tension
- [ ] Stiffness
- [ ] Radiating Pain

What activities, movements, positions or remedies makes your health concern feel better?*

- [ ] Sitting
- [ ] Standing
- [ ] Lying down
- [ ] Sitting to standing
- [ ] Standing to sitting
- [ ] Massage
- [ ] Stretching
- [ ] Medications
- [ ] Cold
- [ ] Heat
- [ ] Other

What activities, movements or positions make your health concern feel worse?*

- [ ] Sitting
- [ ] Standing
- [ ] Lying down
- [ ] Sitting to standing
- [ ] Standing to sitting
- [ ] Massage
- [ ] Stretching
- [ ] Medications
- [ ] Cold
- [ ] Heat
- [ ] Other

Please list any other treatments you have received for this issue and results achieved (ie. surgery, acupuncture, massage therapy, chiropractic care, osteopathic care, physiotherapy) Please include details and dates.*

Does this interfere with:*

- [ ] Work
- [ ] Sleep
- [ ] Daily Routine
- [ ] Quality of Life

Compare this problem at its worst to a time when you feel great! At its worst, how does it stop you from doing things that you enjoy?*

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care), which corrects the most recent layers of spinal and neurological damage. Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Wellness Care). These are the three phases of care. Your chiropractor will weigh your needs and desires when recommending your schedule of care which best fits your health goals. Please check the type of care desired so that we may be guided by your wishes whenever possible:*

- [ ] Wellness Care
- [ ] Corrective Care
- [ ] Relief Care
- [ ] Check here if you want the doctor to select the type of care appropriate for your condition

What are your goals or reasons for seeking chiropractic care ?

Health History (please check all current or previous conditions as they may apply)

General Symptoms*

- [ ] Loss of consciousness
- [ ] Blackouts
- [ ] History of Headaches
- [ ] History of Migraines
- [ ] Fever
- [ ] Excess Sweating
- [ ] Night Sweats
- [ ] Night Pain
- [ ] Generalized Pain
- [ ] Nervousness
- [ ] Convulsions
- [ ] Loss of Sleep
- [ ] Allergies
- [ ] None of the above

Neurological Symptoms*

- [ ] Dizziness
- [ ] Fainting
- [ ] Problem Speaking
- [ ] Blurred Vision
- [ ] Nausea
- [ ] Numbness or tingling
- [ ] Radiating pain
- [ ] None of the above

Eyes / Ears / Nose / Throat Symptoms*

- [ ] Failing Vision
- [ ] Vision Problems
- [ ] Eye Pain
- [ ] Ringing / Buzzing in ears
- [ ] Hearing Loss
- [ ] Other Hearing problems not otherwise listed
- [ ] None of the above

Respiratory Symptoms*

- [ ] Asthma
- [ ] Chronic Cough
- [ ] Difficulty Breathing
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Emphysema
- [ ] None of the above

Cardiovascular Symptoms*

- [ ] Bleeding Disorder
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Previous incident of Stroke
- [ ] Cerebral Vascular Aneurism
- [ ] Hardening of Arteries
- [ ] Swelling of Ankles
- [ ] Poor Circulation
- [ ] Angina
- [ ] Chronic Congestive Heart Failure
- [ ] Previous Heart Attacks
- [ ] Phlebitis / Varicose veins
- [ ] Pacemaker or similar device
- [ ] Other Heart / Blood Disease not discussed
- [ ] None of the above

Gastrointestinal Symptoms*

☐ Jaundice ☐ Irregular or absent bowel movement ☐ Ulcer ☐ Diabetes ☐ Indigestion

☐ None of the above

Genitourinary Symptoms*

☐ Trouble Urinating ☐ Kidney Infection ☐ Prostate Trouble ☐ None of the above

Genitourinary Symptoms (Female only)*

☐ Hot Flashes ☐ Irregular / Absent Cycle ☐ Cramping / Backache ☐ None of the above

Are you currently pregnant ? (if so how many weeks into your pregnancy are you, and your estimated due date)

☐ YES ☐ NO

Number of Pregnancies:

Number of Children:

Have you ever been admitted to the hospital for any reason ? (If Yes, please provide details and dates)*

☐ YES ☐ NO

Please list any and all surgeries including details and dates*

Have you ever had any fractures ? (If Yes, please provide details and dates)*

☐ YES ☐ NO

Have you ever been diagnosed with Cancer ? (If Yes, please provide details and dates)*

☐ YES ☐ NO

Please list your current Medications, Herbs, Supplements.*

Do you suffer from any allergies related to seasons, herbs, foods, animals, drugs, or others ? (If yes, please provide any pertinent detail)

Family Medical History (Please check all applicable conditions)*

- [ ] Headaches or Migraines
- [ ] High or Low blood pressure
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Fainting or Dizziness
- [ ] Stroke
- [ ] Circulatory Problems
- [ ] Cancer
- [ ] Neurological disorders
- [ ] Kidney disease
- [ ] Chron's Disease
- [ ] Pelvic Inflammatory disease
- [ ] Asthma
- [ ] Respiratory disorders
- [ ] Rheumatoid arthritis
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Fibromyalgia
- [ ] Epilepsy
- [ ] Skin Conditions
- [ ] Multiple Sclerosis
- [ ] None of the above

What are your main interests and hobbies?

Please describe your physical activity level, activities you partake in and how frequently you participate.

Please add any additional information that you feel is pertinent

Consents

Chiropractic Intake Form (Adult) — Consents

Accuracy of Information *– Required*

☐ **I certify that the above medical information is correct to my knowledge.**

Privacy and Sharing of Information *– Required*

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ **I agree**

Cancellation policy *– Required*

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24 hours notice, not including weekends, for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee. The cancellation will be up to 100% of the appointment cost. Exceptions based on family or health emergencies will be determined on a case by case basis.

☐ **I am aware of the Cancellation Policy.**

Payment Policy *– Required*

Please note that payment for all appointments is due at the time of service rendered. Appointments conducted at home or on the weekend must be booked with a credit card on file, or pre-paid in-office at least 24 hours prior to the visit. Payment methods accepted on Salt Spring include: credit card, debit, and cash. Payment methods accepted on Mayne and Galiano Island include: credit card and cash. Interac Etransfer is accepted at this time. Credit cards on file are saved within our secure and confidential PIPEDA and PCI compliant medical records system.

Please note that many extended health insurance plans cover chiropractic medicine including visits and treatments.

It is the responsibility of the patient to know the details of their specific coverage and to submit claims. Gulf Islands Chiropractic will provide you with receipts of your visit for the purposes of insurance claims.

☐ **I agree**

Signature *– Required*