36 Coulter Street, Port Perry, ON. Dr. Brock Easter, DC

Chiropractic Intake Form

Name: ______________________________ Occupation: _________________________ Sex: M / F

Date of Birth: ________________________ Date of first appointment: __________________________________

Phone#: ______________________________ Email: ________________________@_______________________

Address: _______________________ City:________________ Province:____ Postal Code: _________

Emergency Contact:_______________________ Tel:_________________ Relation:_________________

Name and telephone number of Primary Care Physician: ____

Address of Primary Care Physician: ____

What is your primary goal of this visit? ____

Please describe your symptoms ____

What aggravates symptoms? ____

What relieves symptoms? ____

Severity (0-10, 10 being worst): _________

Please list **ALL** hospitalizations, injuries, traumas, car accidents and/or surgeries (with dates). If you have more than five, please write them out in chronological order on a separate piece of paper(s) and attach it to this form.

1)

2)

3)

4)

5)

Current medications:____

Other medical conditions? ____

Recent special testing (xray, MRI, blood work)? ____

Do you exercise? yes no (how often?____) What type(s) of exercise?______________________________

Do you smoke? yes no (how much?____)

Present involvement in other health care? yes no

If yes, what type of therapy?___________________________

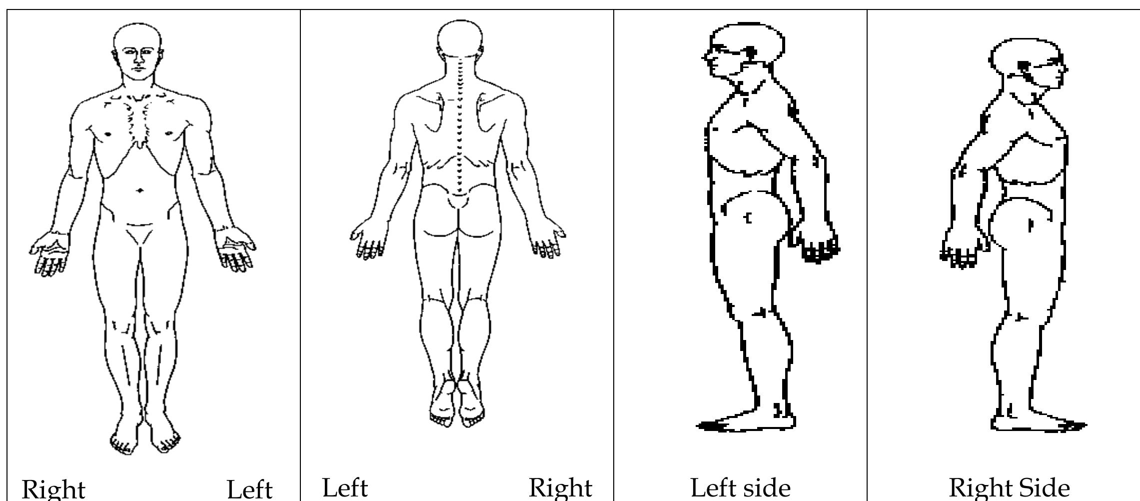
Do you wear orthotics? If yes, why were they prescribed?____

Have you ever sprained your ankle? Which side? How many times? ______________________________________

Please indicate where you are experiencing symptoms using the letter abbreviations below.

Numbness = N Tingling = T Dull Pain = D

Sharp Pain = P Burning = B Stiffness = S



How intense is the pain right now? 0 1 2 3 4 5 6 7 8 9 10

How intense is the pain at its worst? 0 1 2 3 4 5 6 7 8 9 10

Please indicate conditions you are currently experiencing with a "√" and previously experienced with "x".

Respiratory

O Mouth breather
O Nose breather
O Chronic cough
O Cough up blood
O Shortness of breath
O Bronchitis
O Asthma or wheezing
O Emphysema
O Sinus Problems
O Other

Cardiovascular

O Chest pain or tightness
O Palpitations
O Irregular heart beat
O High blood pressure
O Low blood pressure
O Heart attack
O Phlebitis
O Stroke / CVA
O Pacemaker or similar
O Heart disease
O Poor circulation
O Swelling ankles
O Variscoe veins
O Blood clots
O Easy bruising
O Other:_______________.

Infection

O Hepatitis
O Tuberculosis (TB)
O HIV/AIDS
O Skin
O Herpes / Warts
O Other

Head and Neck

O Head trauma
O Previous whiplash
O Concussion
O Previous concussion
O Headache
O Migraines
O Face numbness/tingle
O Vision Problems
O Blurred/Double Vision
O Spots / Floaters
O Cataracts
O Sinus problems
O Ear infections
O Vertigo / Dizziness
O Decreased hearing
O Tinnitus (ear ringing)
O Jaw Pain
O Grinding/Clenching
O Change in taste/smell
O Difficulty Swallowing

Gastrointestinal

O Stomach Pain
O Nausea
O Vomiting
O Irritable bowel
O Diarrhea
O Constipation
O Bloating
O Heart burn
O Gall Bladder Disorder
O Pancreas Disorder
O Recent Weight Change
O Other

Neurological

O Loss of sensation
where? ________________
O Numbness / Tingling
where? ________________
O Muscle spasms
where? ________________
O Muscle weakness
where? ________________
O Seizures
O Tremors
O Paralysis
O Other_______________.

Skin

O Hives
O Rashes
O Eczema
O Plantar warts
O Night sweats
O Excessive sweating
O Bruise easily
O Changes in moles
O Other

Female

O Pregnant (due):_______
O Pelvic Inflammatory Disease
O Menstrual Pain
O Menopausal Symptoms
O Birth control pill
O Kids (how many)
____

Other Concerns

O Dizziness / Vertigo
O Diabetes
O Bladder Changes
O Night Pain
O Night Sweats
O Fever
O Other_________________.

	O Other________________.		