FIRST CARE CENTRE

Thank you for choosing us for your therapy! Please fill out this intake form as thoroughly as possible. Feel free to ask any questions about any information being requested. All information gathered for this treatment is confidential. Email addresses are only used for appointment confirmations, reminders, cancellations, and occasional clinic news. Your written permission will be required to release any information.

PATIENT INFORMATION

Name: _____ Birth date (MM/DD/YY):___/___/___ M / F

Address: _____ City: _____ Postal Code: _____

Tel (Home): _____ (Cell): _____ (Work): _____

Email: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Medical Doctor (Name & #): _____ If needed, may we contact them? Y/N

Have you had a physical in the last year? Y / N

Do you have Extended Health Benefits? Y / N If yes, what company? _____

Are you a MVA or WSIB case? Y / N

How did you hear about us?

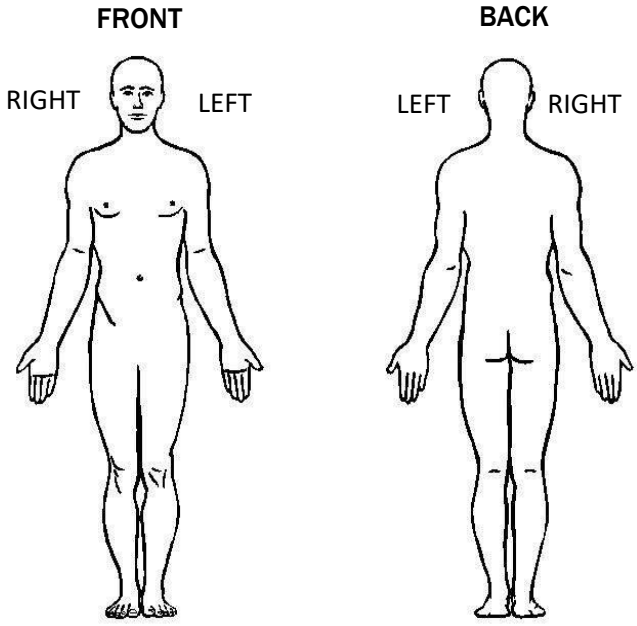
- ☐ Friend: _____ ☐ Website: _____ ☐ Ad: _____
- ☐ Family Member: _____ ☐ Doctor: _____ ☐ Other: _____

CURENT HEALTH HISTORY

Current complains & when they started: _____

_____

On drawing on the right, mark painful areas with an X



Describe the Pain:

- ☐ Sharp & Stabbing
- ☐ Dull ache
- ☐ Burning
- ☐ Numbness
- ☐ Pins & Needles
- ☐ Stiff & Tight
- ☐ Other

What aggravates your condition?

- ☐ Sitting
- ☐ Laying down
- ☐ Standing
- ☐ Bending
- ☐ Dressing Self
- ☐ Cold/Dampness
- ☐ Other

What relieves your condition?

- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Other
- ☐ Massage
- ☐ Medication
- ☐ Changing positions

Is your condition getting:

☐ Worse ☐ Better ☐ Constant ☐ Other:_____

Have you had this condition before? Y / N

What other therapies have you tried (previous and current):

- ☐ Chiropractic
- ☐ Physiotherapy
- ☐ Massage
- ☐ Acupuncture
- ☐ Naturopath
- ☐ Other: _____

What are your goals for therapy? _____

Rate the following by circling a number:

Level of pain right now	None	1	2	3	4	5	6	7	8	9	10	Worst
Level of pain at its worst	None	1	2	3	4	5	6	7	8	9	10	Worst
General level of stress	None	1	2	3	4	5	6	7	8	9	10	High
Level of physical activity	None	1	2	3	4	5	6	7	8	9	10	High

Currently exercising? Y / N If yes, what kind? _____

Medications & supplements you are currently taking? _____

_____

Know allergies: _____

Ongoing medical conditions: _____

Do you currently smoke? Y / N If yes, how much? _____
Did you previously smoke? Y / N If yes, how much? _____
Do your wear orthotics? Y / N
Females:
Are you pregnant? Y / N
Are you currently taking birth control? Y / N

FAMILY HEALTH HISTORY

Do you or anyone in your family have a history of the following?

- ☐ Cancer _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Headaches/Migraines _____
- ☐ Anxiety disorders_____
- ☐ High Blood Pressure _____
- ☐ Multiple Sclerosis _____
- ☐ Severe Arthritis _____
- ☐ Stroke _____
- ☐ Other _____

PAST HEALTH HISTORY

Have you had an x-ray this year? Y / N If yes, where & why? _____

List previous accidents/ traumas & when they happened _____

List previous fractures & when they happened _____

List previous surgeries /traumas & when they happened _____

Questions/concerns? _____