Dr. Jeanette Amato
CHIROPRACTOR

ADULT INTAKE FORM

Name: _____ Birthdate: _____ Age: _____

Address: _____ Gender: Male __ Female __ Other: _____

City: _____ Postal Code: _____ Phone (cell): _____

Email: _____ Phone (other): _____

Occupation: _____ Employer: _____

Alberta Health Care #: _____

*Please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment, and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Thrive Chiropractic & Wellness Centre.

Emergency Contact Name: _____ Phone: _____

Parent Contact (if patient is <18 years of age): _____

Are you currently a **student**? Yes ____ No ____

Is there a chance you could be **pregnant**? Yes ____ No ____

Is this related to a **motor vehicle accident**? Yes ____ No ____

If yes, date of accident: _____

Is this related to a workplace injury (**WCB claim**) Yes ____ No ____

____ I give consent to receive emails and / or text messages for appointment reminders and important office information. We will not share your email or contact information with any third party.

Who can we thank for referring you to our office? _____

If you were not referred by a friend or family, how did you hear about our office?_____

Have you been to a Chiropractor before? Yes No

If Yes, who _____ When was your last visit? _____

Do you wear orthotics or special shoe inserts? Yes No If yes, how old are they? _____

Have you received **spinal x-rays** in the past 2 years? Yes No

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Current Health Condition

Reason for visit: ___ Wellness ___ Specific Concern

Describe Primary Concern:

_____

When did it start?

_____

Have you received care for this problem? If yes, please explain:

_____

Have you experienced a similar problem in the past? __ Yes __ No When: _____

How did the condition(s) first begin?

_____

What makes the problem better?

_____

What makes it worse?

_____

Is the problem: __ Getting Worse __ Improving __ No Change

How frequent is this problem? __ Constant __ Daily __Weekly Other:_____

Is the condition: __ Intermittent (on and off) __ Constant __ Unsure

Describe the pain:

__ Aching __ Sharp __ Numb __ Dull __ Burning __ Tingling __ Deep __ Throbbing
Other: _____

On a scale of 1 (no pain) to 10 (severe pain), rate your pain: ____average ____ at best ____ at worst

Health History

Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

__ Rheumatoid Arthritis __ Diabetes __ Lupus __ Heart Disease

__ High Blood Pressure __ Stroke __ Cancer

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Please check any symptoms currently affecting your quality of life
(even if you do not believe them to be chiropractic related)

___ Headaches/Migraines
___ Neck Pain
___ Upper Back Pain
___ Lower Back Pain
___ Chest Pain
___ Shoulder Pain
___ Arm/Wrist/ Hand Pain
___ Chest / Rib Pain
___ Sciatic Pain
___ Leg Pain
___ Hip Pain
___ Knee Pain
___ Foot Pain/Numbness
___ TMJ / Jaw Pain
___ Joint swelling
___ Concussion
___ Fatigue
___ Sleeping Problems
___ Heartburn
___ Constipation
___ Diarrhea
___ Bloating/Gas
___ Shortness of Breath
___ Scoliosis
___ Allergy/Sinus Problems
___ Excessive Thirst
___ Frequent Urination
___ Dizziness/Vertigo
___ Vision Changes
___ High Blood Pressure
___ Cramping in Legs
Other: _____
___ Frequent Colds/Flus
___ Chronic Cough
___ Asthma
___ Ear Infections
___ Cancer
___ Bladder Control
___ Sexual Dysfunction
___ Depression
___ Anxiety
___ ADD/ADHD
___ Heart Disease
___ Dermatitis/Eczema
___ Arthritis
___ Osteoporosis
___ Loss of Memory

WOMEN ONLY
Are you pregnant?: _____ Due Date: _____

Are you currently nursing? _____

Have you experienced any of these:
___ Painful Menstruation
___ Miscarriage
___ Endometriosis
___ Irregular Cycles
___ Early Menopause
___ PMS
___ Infertility
___ Hot Flashes

# of pregnancies _____
___ C- Section
___ Forseps
# of births _____
___ Epidural
___ Vacuum Suction
___ Induction
___ Breech Baby

Traumas: Physical Injury History

Have you had any significant falls, surgeries, accidents or injuries as an adult?__Yes __ No

If yes, please explain:_____

Have you ever been hospitalized? __ Yes __ No

If yes, why? _____

Notable childhood injuries? _____

Youth or college sports? _____

Describe any car accidents you've been in: _____

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Lifestyle

Exercise Frequency: __ 1-2x/week __ 3-5x/week __ Daily __ Occasionally __ Never

What types of exercise do you perform? _____

How do you normally sleep? __ Back __ Side __ Stomach

Do you have difficulty: __ Falling asleep? __ Staying asleep? __ Both

How many hours a night do you typically sleep? _____

Do you wake up: __ Refreshed __ Stiff & Tired __ With a headache

Do you commute to work? __ Yes __ No

How many minutes per day do you commute to work? _____

How many hours per day do you typically spend sitting? _____

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each: (1=never, 5=high)

__ Alcohol __ Water __ Sugar __ Dairy __ Gluten __ Caffeine

__ Processed Foods __ Artificial Sweeteners __ Sugary Drinks __ Cigarettes/Tobacco

__ Recreational Drugs __ Fast Food

Allergies:

_____

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking, and why:

_____

_____

Thoughts: Emotional Stress

Please rate your STRESS for each: (1=none, 5=high)

__ Home __ Work __ Life __ Money __ Health __ Family

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Accuracy of Information – PLEASE INITIAL

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

Privacy and Sharing of Information – PLEASE INITIAL

____ 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.

_____ _____

Patient Name Guardian Name (if applicable)

_____ _____

Patient Signature Guardian Signature (if applicable)

_____

Date

_____

Dr. Jeanette Amato

_____

Date