

Bellevue Natural Health Clinic
Chiropractic
New Patient Intake Form

Date: _____

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PATIENT INFORMATION

Name: _____

Address: _____

D.O.B: ___/___/_____ Age: _____ Male / Female

Care Card Number: _____

Occupation: _____

Employer: _____

Parents Name (if a minor): _____

Single Married Widowed Separated

Do you have children? If so, how many? _____

What are you seeking?

Temporary Relief Optimum Corrective Care

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CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

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ACCIDENT INFORMATION

Is your condition due to an accident? Yes No

If yes, please report to front desk for additional forms

To whom have you reported the accident?

ICBC WCB Employer Other: _____

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REFERRAL INFORMATION

How did you discover our office?

Friend/Family Member

Yellow Pages

Sign

Other: _____

If referred, whom may we thank for referring you to our clinic?

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PATIENT CONDITION

What is your major symptom/complaint? _____

When did your symptoms begin? _____

Have you had this complaint before? _____

Is your condition getting progressively worse? Yes No

Is this complaint: Constant Comes and goes

How does it feel? Burning Sharp Shooting Dull

Aching Stiff Tingling Other

Please circle the severity of your pain on a scale of 1 to 10

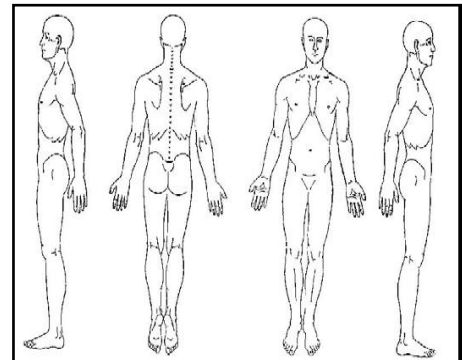
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe Pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Please mark where it hurts (x)



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HEALTH HISTORY

What other treatments have you had for this condition?

Orthopedic Neurologist Physical Therapy Medication Surgery Massage

Have you had previous Chiropractic care? Yes No Name of doctor: _____

Have you recently had any X-Rays taken or other special imaging such as and MRI or CT Scan? _____

If Yes, what type - body part/reason for imaging: _____

Please list any medications you are taking: _____

Vitamins/ Herbs/ Minerals: _____

Please check any of the following conditions that apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Leg Pain/Knee Pain | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Back Pain | |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Neck Pain | |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Osteoporosis | |

Stressors

- Smoking
- Alcohol
- Coffee/Caffeine
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Exercise

- None
- Moderate
- Daily
- Heavy

Have you had any:

Description

Date

Surgeries _____
 Broken Bones _____
 Falls/Head Injuries _____

This Section is Women Only:

Are you Pregnant? Yes No Maybe

Are you taking birth control? Yes No

Ladies, Please check any of the following that are relevant to your medical history:

- Cramps/Backache Excessive Menstrual Flow Irregular Cycle Hot Flashes
- Painful Menstrual Flow Menopausal Symptoms

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AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any payment that is not covered by the Medical Services Plan or other parties including WCB and ICBC.

Patient's Name (Please Print)

Patient's Signature/Parent or Guardian if minor

Date

Witness/Stamp

Thank you fro choosing our Chiropractic office. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.