Office use Only:
Your chiropractor is
☐ Dr. Jennifer Treamain
☐ ____________

Referral Source:
☐ Internet
☐ Facebook
☐ Twitter
☐ Google
☐ Friend / Family
☐ GP / Midwife
☐ Leaflet
☐ Talk / Event

Chiropractic Intake & History

Please answer all the questions so we can assess how we can best help you

Patient Information

Patient First Name ____________________
Patient Last Name ____________________
Middle Initial ________
Address ____________________
City ____________________
Prov ______________ Postcode ____________
Home Phone ____________________
Mobile Phone ____________________
Email ____________________
☐ I give my consent to be added to the email newsletter to receive recent news, events and healthy tips.

Sex ☐ Male ☐ Female
Age ________
Birthday ____________________
Employer/School ____________________
Occupation ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Family Information

Children Names and Ages:

Partner Name ____________________
Partner Employer ____________________
Partner Occupation ____________________

MD Name ____________________

Who can we Thank for referring you to our office?
____

How can we help you?

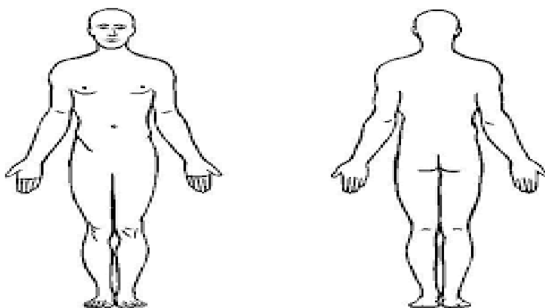
What brings you in today?
____

How bad is it? How intense are your symptoms?

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

No Symptom — Intense Symptoms

Please circle where the pain or other symptoms are:



If you are already experiencing symptoms, what are they?
____

Are your symptoms improving?
☐ Yes ☐ No ☐ No Change

What does it feel like? (Check where appropriate)
☐ Numbness ☐ Sharp ☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning ☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing ☐ Cramping ☐ Swelling
☐ Nagging ☐ Other ____________________

Have you seen any other professional for the above complaint(s)?
☐ MD ☐ Consultant Surgeon ☐ Physician
☐ Osteopath ☐ Acupuncture

Have you had
☐ MRI ☐ X-ray ☐ CT ☐ Blood tests
☐ Other ____________________

Old Injuries

Please list any historic injuries, when they occurred, what age you where and what treatment you received for them:

Are any of the injuries listed causing current issues?
____

Impact of Your Symptoms

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ________	☐	☐	☐	☐

What makes it better? ____

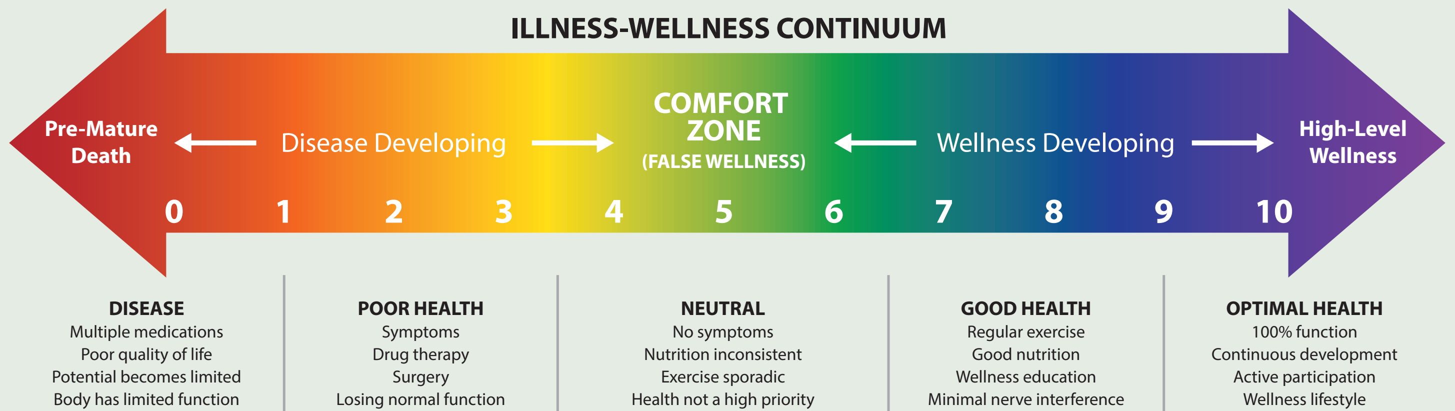
What makes it worse?____

How committed are you to working towards your optimal health?

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Not Committed — Very Committed

Patient Wellness Assessment



On the diagram above:

A. What number do you think represents your health today? __________

B. In what direction (left or right) is your health currently headed? __________

What would you like to get out of your chiropractic care?

____

What are your health goals?

Immediate ____

5 years____

10+ years____

Health & Illness History

Please check the box beside any condition that you have or have had.

Past	Present	Condition
☐	☐	AIDS/HIV
☐	☐	Alcoholism
☐	☐	Anxiety
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Asthma/Allergies
☐	☐	Back Pain
☐	☐	Cardiovascular Issues
☐	☐	Cancer

Past	Present	Condition
☐	☐	Circulation Issues
☐	☐	Childhood Illness
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Digestive Issues (Constipation/Diarrhoea/GERD/IBS)
☐	☐	Elbow/Wrist/Hand Issues
☐	☐	Endocrine Issues (Thyroid)
☐	☐	Foot/Ankle Issues

Past	Present	Condition
☐	☐	Gout
☐	☐	Headaches/Migraines
☐	☐	Heart Disease
☐	☐	Hip Issues
☐	☐	Immune Issues
☐	☐	Lymphatic Issues
☐	☐	Multiple Sclerosis
☐	☐	Neck Pain
☐	☐	Reproductive Issues

Past	Present	Condition
☐	☐	Ringing in Ears
☐	☐	Scoliosis
☐	☐	Shoulder Issues
☐	☐	Stroke
☐	☐	Jaw Pain
☐	☐	Urinary Issues
☐	☐	Osteoporosis
☐	☐	Other

____

Family History Review

Please tick those involving immediate family and add identification:
M = Mother **F** = Father **S** =Sibling **G** = Grandparents

☐ **Cancer**, type____________________________
☐ M ☐ F ☐ S ☐ G

☐ **Heart Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Lung Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Seizures/Epilepsy**
☐ M ☐ F ☐ S ☐ G

☐ **Depression**
☐ M ☐ F ☐ S ☐ G

☐ **Liver Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Scoliosis**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoarthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Diabetes**
☐ M ☐ F ☐ S ☐ G

☐ **High Blood Pressure**
☐ M ☐ F ☐ S ☐ G

☐ **High Cholesterol**
☐ M ☐ F ☐ S ☐ G

☐ **Rheumatoid Arthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Back Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Neck Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Headaches/Migraines**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoporosis**
☐ M ☐ F ☐ S ☐ G

☐ Other
____

Allergies, Medications & Supplements

Allergies (list)

Medications (list)

Supplements (list)

We would like to thank you once again for taking the time to complete ALL the questions, we really appreciate it! Welcome to the practice, sit down, relax and let us take care of your body!

Your Chiropractor will be with you shortly