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# PATIENT INTAKE FORM - **CHIROPRACTIC**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date (D/M/Y):\_\_\_\_\_\_ /\_­­\_\_\_\_ /\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Assigned Gender: □Female □Male Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OHIP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version Code: \_\_\_\_\_\_\_

 Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Please mark where the pain is located.*

## **ADDRESSING THE ISSUE THAT BROUGHT YOU TO OUR OFFICE**

1. What is your major symptom/
problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When did your symptoms begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you had this problem before? □Yes □No
4. Is the problem there □constant □comes & goes □with use □at rest?
5. Is the problem getting □worse □no change □better?
6. What makes it worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. What makes it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. How does it feel? □Burning □Sharp □Shooting □Dull □Stiff □Aching □Tingling □Throbbing

□Swelling □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you rate the sensitivity of your pain (0=no pain, 10=severe pain)? \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does it interfere with your: □Work □Sleep □Daily Routine □Recreation?
3. What test have you had for this condition? □Spinal Exam □X – ray □MRI □CT Scan
4. Have you received any treatment for this condition? □Orthopedic □Physiotherapy □Massage Therapy □Acupuncture □Surgery (Date D/M/Y: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medi**

**cations**

**Allergies**

**Supplem**

**entations**

**Patient Health Questionnaire**

Please check ( ) if any of the following apply to you. Knowledge of these conditions may influence the type of treatment you receive.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |  | YES | NO |  | YES | NO |
| AIDS/HIV |  |  | Diabetes |  |  | Liver Disease |  |  | Rheumatoid Arthritis |  |  |
| Alcoholism |  |  | Emphysema |  |  | Measles |  |  | Rheumatic Fever |  |  |
| Allergy Shots |  |  | Epilepsy Fractures |  |  | Migraine headaches |  |  | Scarlet Fever |  |  |
| Anemia |  |  | Glaucoma |  |  | Mononucleosis |  |  | Sexually Transmitted Disease |  |  |
| Anorexia |  |  | Goiter |  |  | Multiple Sclerosis |  |  | Stroke |  |  |
| Appendicitis Arthritis |  |  | Gonorrhea |  |  | Mumps |  |  | Suicide Attempt |  |  |
| Asthma |  |  | Gout |  |  | Osteoporosis |  |  | Thyroid Problems |  |  |
| Bleeding Disorders |  |  | Heart Disease |  |  | Pacemaker |  |  | Tonsillitis |  |  |
| Breast Lump |  |  | Hepatitis |  |  | Parkinson’s Disease |  |  | Tuberculosis |  |  |
| Bronchitis |  |  | Hernia |  |  | Pinched Nerve |  |  | Tumors, Growths |  |  |
| Bulimia |  |  | Herniated Disc |  |  | Pneumonia |  |  | Typhoid Fever |  |  |
| Cancer |  |  | Herpes |  |  | Polio |  |  | Ulcers |  |  |
| Cataracts |  |  | High Blood Pressure |  |  | Prostate Problem |  |  | Vaginal Infections |  |  |
| Chemical Dependency  |  |  | High Cholesterol |  |  | Prosthesis  |  |  | Whooping Cough |  |  |
| Chicken Pox |  |  | Kidney Disease |  |  | Psychiatric care |  |  | Other: |  |  |

Are you pregnant?: □No □Yes How many weeks? \_\_\_\_\_\_\_\_

HAVE YOU EVER:
Had an accident (car,fall,sport,other)? □No □Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had an operation? □No □Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had a fracture? □ No □Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been hospitalized? □No □Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY: Have your grandparents, parents or siblings ever been diagnosed with any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| □□□□□□ | High Blood PressureHeart StrokeStrokeDiabetes (Type I or Type II)Thyroid/ Hormone ProblemsBreathing or lung problem | □□□□□□ | Rheumatoid ArthritisOsteoarthritisNeurological problemsCancer Kidney Disease Other (specifiy): |

I certify that all the above personal health information, on page one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Informed Consent to Examine: By signing I am allowing Dr. Trevor Deleo to conduct a thorough neuro/orthopeadic examination with the intent to diagnose musculoskeletal disorders.

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (D/M/Y) \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_