DYNAMIC
CHIROPRACTIC & SPORTS
THERAPY CENTER

NEW PATIENT INTAKE FORM

MHSC# **DATE OF BIRTH (D/M/Y)** **AGE**

NAME **PHONE**

ADDRESS **EMAIL**

Have you had previous chiropractic care? Yes No

When? Doctor/Clinic:

What were you treated for?

Have you had X-rays? Yes No

Do you have a Health Insurance Policy? Yes No Company Name:

Occupation: Gender:

Main Complaint:

Location:

How did it start?

When did it start?

How often do you feel it (25% of the time, half the day, all day)?

Does it radiate anywhere?

What type of pain is it (sharp, shooting, dull, achy, tight)?

How bad is the pain (0-10 scale. 0 – no pain, 10 – unbearable)?

What makes it worse?

What makes it better?

Does it wake you up at night?

Any numbness or tingling?

PAST HISTORY			**FAMILY HISTORY**			**PROBLEMS/RISKS**
Cancer	Y	N	Cancer	Y	N	
Diabetes	Y	N	Diabetes	Y	N	
Stroke	Y	N	Stroke	Y	N	
Cardio-vascular	Y	N	Cardio-vascular	Y	N	
Epilepsy	Y	N	Epilepsy	Y	N	
Surgery	Y	N	Main Complaint	Y	N	
Significant Falls	Y	N	Athritis	Y	N	
Auto Accidents	Y	N				
Current Medication	Y	N				