# Intake Form

Chiropractic Generation
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(613) 966-4725

## Welcome

Welcome to Chiropractic Generation!

WHAT TO EXPECT

YOUR FIRST VISIT

During your first visit we will go through a discovery process with you, to determine the source of your health concerns.

THIS WILL INCLUDE:

A DETAILED HEALTH HISTORY with one of our exam specialists.

A THOROUGH SPINAL EXAMINATION to determine any abnormal alignment and motion patterns, and also to discover how this is detrimentally affecting your central and peripheral nerve systems and organ function.

Sending you for ANY FURTHER IMAGING STUDIES that may be necessary such as x-rays.

YOUR NEXT APPOINTMENT

After the examination, if your doctor determines that you area a good candidate for reconstructive or structural Chiropractic care, he will then arrange for your next visit, which is the DOCTOR'S REPORT. The purpose of the DOCTOR'S REPORT is to review the findings from your consultation and examination.

At the DOCTOR'S REPORT, the doctor will give a detailed overview of how structural Chiropractic works and the scientific evidence supporting the specialized work that we do here. This will be done in a SMALL GROUP SETTING with other new patients.

We know that there is tremendous power in you fully understanding your problem and how we will work with you to correct it. This is why the DOCTOR'S REPORT is detailed and very informative.

We ask that your spouse come to the DOCTOR'S REPORT with you. Health information can be complicated and it can be difficult to explain your results to your spouse if they are not present at the REPORT. Having support

and understanding at home is important to your complete recovery.

After the presentation your doctor will privately review the results of your EXAMINATION AND X-RAYS. HE WILL OUTLINE A COURSE OF CARE, discussing how long it will take to correct your spine, how often you will come in for adjustments, and the financial investment for your care and correction. At that point you will be able to decide how you would like to proceed.

YOU ARE IN GOOD HANDS. Your health is our #1 priority.

Thank you for giving us the privilege to determine if we can help you OPTIMIZE YOUR HEALTH.

Sincerely,

Dr. Stephen Lippitt and the Chiropractic Generation Team

Please complete the following pages to save time and help us to serve you better. Thank you.

## Contact

First we need your personal contact information.

First Name _____

Last Name _____

Address _____

City _____ Prov _____ Postal _____

Home Phone _____ Cell Phone _____

Other Phone _____ Email _____

Gender Male Female Birthdate _____

Height _____ Shoe Size _____ Weight _____

Marital Status Single Engaged Married Common-Law Divorced Widowed

Spouse _____ Num. of Children _____ Name/Ages _____

Emergency Contact _____ Emergency Contact Phone _____ Relationship _____

How did you hear about us? Location Patient Friend Physician Advertisement Special Offer Web/Google Social Media

_____

Family Physician _____ Physician Phone _____ Physician Location _____

# Intake Form

Work Status Full Time Part Time Disability Student Retired Unemployed

Employer _____ Occupation _____ Employer Phone _____

Employer Address _____

Do you have extended health coverage for chiropractic care? Yes No

Own Coverage? Yes No

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Spousal/Parent Coverage? Yes No

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Office policy regarding insurance & health benefits:

We will provide you with the necessary statements for the care you receive and pay for at our clinic so you can make a claim to your insurance provider for personal reimbursement.

## Discovery

Supplements Yes No

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Sleep Position Back Left Side Right Side Stomach

Physical, chemical and emotional stress, both past and present, could be contributing reasons or risk factors to your current condition and health. Please provide as much detail as possible.

Physical Trauma History Fractures

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Auto Accident

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Work Injury

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Falls

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Hospitalization

# Intake Form

Spinal Injury

Childhood Injury

Sports Injuries

Lifting or Impact Injuries

Posture Stresses & Habits Sitting More than 6 hours Head forward posture Desk work Prolonged Computer/screen time Prolonged Standing Stomach sleeper Overweight

Participate in physical/high impact activities Contact sports

Running Basketball Climbing Cycling Skating Weight Lifting Other Other

Occupational Stresses

What is your occupation? _____

Regular tasks required? (list) _____

Any previous work injuries? _____

Birth Trauma or In-Utero Stresses Forceps C-Section Suction Extraction Resuscitation Difficult Epidural In-Utero Stress

Chemical Stresses

Alcohol Use None Daily Weekly

Coffee Use None Daily Weekly

Tobacco Use None Daily Weekly

Pain Relievers None Daily Weekly

Soft Drinks None Daily Weekly

Medications None Daily Weekly

# Intake Form

Over the counter drugs None Daily Weekly

Recreational drugs None Daily Weekly

Artificial sweeteners None Daily Weekly

'Junk' foods None Daily Weekly

'Processed' foods None Daily Weekly

Other chemical/ toxin exposure None Daily Weekly

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Current Medications Blood Pressure Insulin Muscle Relax. Nerve Pills Pain Other

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Lifestyle & Nutrition

Are you physically active and/or exercise at least 30 minutes per day? Yes No

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Exercise None Daily Weekly

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Stretching None Daily Weekly

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Water Intake None 1-2 Cups 3-5 Cups 6-9 Cups > 1 Litre

Do you feel like you make healthy food choices? Yes No I don't know

Fruits/Vegetables: None Daily Weekly

High lean protein: None Daily Weekly

Daily Meditation/Prayer: None Daily Weekly

Organization/Daily Planner: None Daily Weekly

Goal setting/personal development: None Daily Weekly Monthly Yearly

How much sleep do you get per day/night? < 3 Hours 4-5 Hours 6-7 Hours 8+ Hours

What changes in your daily lifestyle do you want to change? _____

DISCOVERY of past or present problems or illnesses within your different BODY SYSTEMS is important. Please indicate your age at diagnosis or occurrence of any such problems and any other relevant details.

# Intake Form

Personal Illness History Aids Alcoholism Allergies Arteriosclerosis Cancer Chicken Pox Diabetes Epilepsy Glaucoma Goiter Gout Heart Disease Hepatitis HIV Positive Malaria Measles Multiple Sclerosis Mumps Polio Rheumatic Fever Scarlet Fever STD Stroke Tuberculosis Typhoid Ulcer Other

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Musculoskeletal Osteoporosis

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Back Problems

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Knee Injuries

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Arthritis

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Hip Disorders

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Foot/Ankle Pain

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Scoliosis

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TMJ Issues

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Shoulder Problems

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Neck Pain

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Poor Posture

---

Elbow/Wrist Pain

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# Intake Form

Neurological Anxiety

Headaches

Dizziness

Depression

Numbness

Pins and Needles

Cardiovascular High Blood Pressure

Poor Circulation

High Cholesteral

Low Blood Pressure

Chest Pain

Digestive Anorexia or Bulimia

Constipation

Food Sensitivities

Ulcer

# Intake Form

Diarrhea

Heartburn

Respiratory Asthma

Shortness of Breath

Emphysema

Apnea

Pneumonia

Allergies

Sensory Blurred Vision

Nose Bleed

Chronic Ear Infections

Ringing in Ears

Sore Throat

Loss of Smell

# Intake Form

Hearing Loss

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Integumentary Skin Cancer

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Rash

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Acne

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Psoriasis

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Bruise Easily

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Hair Loss

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Eczema

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Slow Healing

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Endocrine Thyroid Issues

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Swollen Glands

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Low Blood Sugar

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Immune Disorder

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Low Energy

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Frequent Infection

# Intake Form

Genitourinary Kidney Stones

Prostate Issues

Bedwetting

Infertility

PMS Symptoms

Allergies Peanuts Gluten Dairy Other

General Fainting

Loss of Appetite

Sudden Weight Gain

Fatigue

Loss of Sleep

Weakness

Sudden Weight Loss

Surgery/Trauma History Cancer Back Surgery Bypass Surgery Hernia Other

# Intake Form

## Family History

Father Not Applicable/Unknown

Age

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Age At Death

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Health Fair Good Poor

Illnesses

---

Mother Not Applicable/Unknown

Age

---

Age At Death

---

Health Fair Good Poor

Illnesses

---

Brother Not Applicable/Unknown

Age

---

Age At Death

---

Health Fair Good Poor

Illnesses

---

Sister Not Applicable/Unknown

Age

---

Age At Death

# Intake Form

Health Fair Good Poor

Illnesses

Emotional/Mental Stresses Marriage

Kids

Parents/siblings

Finances

Work

Elderly Parents

Recent Major Life Events (deaths, births, new job, relocation, other)

## Condition

What are the symptom(s), condition(s), or reason(s) for you seeking our help today? _____

Have you seen other chiropractors for your condition(s)? Yes No

Have you seen a medical doctor for your condition(s)? Yes No

Were any special tests conducted or scheduled in the near future? Yes No

Have you ever had spinal x-rays taken? Yes No

# Intake Form

Prior Interventions:_____

Is your condition or any of your symptoms related to: Auto Accident Work Injury Sports Injury Home Injury Other

_____

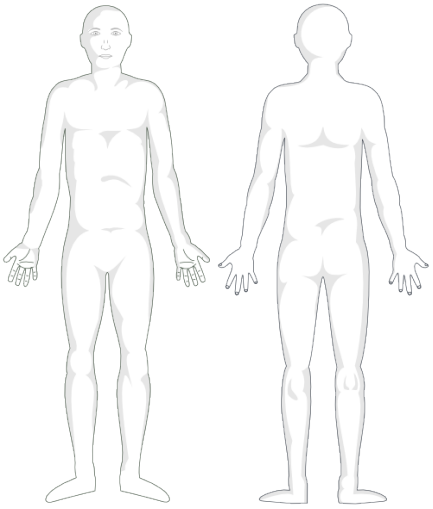
Is your condition related to an automobile accident or personal injury insurance claim? Yes No

_____

Is your condition related to a WSIB claim Yes No

_____

Please click on the body parts where you are experiencing pain or symptoms. Provide as much detail as possible including areas where you feel radiating symptoms into arms, hands, legs, feet or other body parts.



How long ago did your problem first start?_____

_____

_____

_____

Rate the severity of your pain from 0 to 10

0 1 2 3 4 5 6 7 8 9 10

No Pain Excruciating Pain

# Intake Form

How frequent do you feel your symptoms? Constant Daily Off and On Weekly Occasionally

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Does anyone from your family suffer from the same condition? Yes No

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What makes the condition worse? Bending Coughing Defecation Lifting Sitting Sneezing Stairs Standing Walking Other

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What makes the condition better? Bed Rest Heat Ice Massage Medication Other

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What else should we know about your current condition? _____

## Impact

Does your condition affect your employment? Yes No

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Does your condition affect your sleep? Yes No

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Has your condition affected your quality of life?


Not at All Severely

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Has your condition affected you emotionally?


Not at All Severely

---

Has your condition affected your family life and/or relationships?


Not at All Severely

---

# Intake Form

If uncorrected, how do you see your condition affecting your life over the next 1-5 years?_____

If we were having a conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

What is your greatest motivation (other than pain) for seeking out a solution for your condition? Mobility

Quality of Life Health Improvement Performance Family Work Sports Participation Relationships

Other

_____

Do you believe that your condition can improve? Yes No I don't know

How do you want us to handle your symptoms and health? Relief Care Only Maximum Correction

Wellness Care

How committed are you at achieving your maximal health potential?


I realize that x ray examinations may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant.

Yes No

Last Cycle: _____

## Finalize

Please Read the following carefully before signing.

PLEASE READ CAREFULLY

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I

understand that Chiropractic care is considered very safe with an extremely low-risk rate. I further understand that there are, however, some risks associated with chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

In particular, I understand that in rare cases there have been reported incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapists, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements, including turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to a stroke. The risk of stroke after cervical adjustment is estimated at 1 in 1,000,000, substantially lower than that associated with any medical or other treatment medications or procedures for the same symptoms. To put this in perspective, studies that have assessed the risk from interventions a non-Chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries for neck pain: 15,600 per million

Risk of death from surgeries for neck pain: 6,900 per million

Risk of serious gastrointestinal event from non-steroidal

anti-inflammatory drugs: 1,000 per million

I understand that while rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments. I also understand that there have been rare reported cases of disc injuries following cervical and lumbar adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused by chiropractic treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I have read and understood the above, and I have had sufficient opportunity to discuss its content with the Doctor of Chiropractic indicated below. I do hereby request and consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic indicated

below, for my present condition and for any future conditions for which I may seek care. I also agree to payment for all services rendered.

Signature