

# Adult Intake

Beyond Wellness Chiropractic  
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Brampton, ON L7A 0P1  
905-970-9355

## Introduction

## Contact

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** **Married** **Divorced** **Widowed**

Spouse \_\_\_\_\_ Num. of Children \_\_\_\_\_ Names/Ages \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us? **None** **Patient** **Physician** **Attorney** **Advertisement**

Family Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Physician Phone \_\_\_\_\_

Work Status **Full Time** **Part Time** **Disability** **Student** **Retired** **Unemployed**

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

Have you missed work due to this injury? **Yes** **No**

Missed work start date? \_\_\_\_\_ Return or anticipated return date \_\_\_\_\_

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## Condition

The Symptoms that have prompted you to seek care today include: \_\_\_\_\_

Have you seen other doctors for this condition? Yes No

Prior Interventions Acupuncture Chiropractic Heat Homeopathic Ice Massage Medication OTC Meds  
Physiotherapy Surgery Other

What is the condition related to? Auto Accident Home Injury Sports Injury Work Injury Other

When did your problem first start? \_\_\_\_\_

Have you had this condition before? Yes No

Does the pain radiate or travel to other parts of the body? Yes No

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

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

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

Does this condition affect employment? Yes No

Does this condition affect recreation? Yes No

Does this condition affect household? Yes No

Does this condition affect personal? Yes No

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Does this condition affect sleep?  Yes  No

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What else should we know about your current condition? \_\_\_\_\_

Rate the severity of your pain from 0 to 10



No Pain

Excruciating Pain

Pain Duration  Constant  Intermittent

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Current Medications  Blood Pressure  Insulin  Muscle Relaxants  Nerve Pills  Pain  Other

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Supplements  Yes  No

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Sleep Position  Back  Left Side  Right Side  Stomach

Hours of sleep per night? (1-24) \_\_\_\_\_

Have you had x-rays in the last six months?  Yes  No

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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.

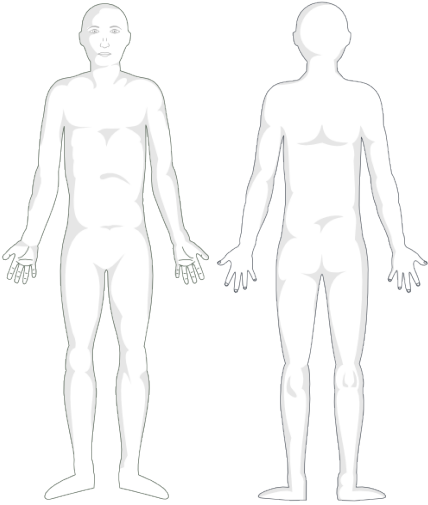
Yes  No

Last Cycle: \_\_\_\_\_

## Pain

Please Select the Area(s) that you are experiencing pain?

# Adult Intake



## Systems

Select options below indicating age at diagnosis and other relevant details.

Musculoskeletal    Osteoporosis

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Back Problems

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Knee Injuries

---

Arthritis

---

Hip Disorders

---

Foot/Ankle Pain

---

Scoliosis

---

TMJ Issues

---

# Adult Intake

Shoulder Problems

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Elbow/Wrist Pain

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Neck Pain

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Poor Posture

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Neurological    Anxiety

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Headaches

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Dizziness

---

Depression

---

Numbness

---

Pins and Needles

---

Cardiovascular    High Blood Pressure

---

Poor Circulation

---

High Cholesterol

---

Low Blood Pressure

---

Chest Pain

# Adult Intake

---

Respiratory   Asthma

---

Shortness of Breath

---

Emphysema

---

Apnea

---

Pneumonia

---

Allergies

---

Digestive   Anorexia or Bulimia

---

Constipation

---

Food Sensitivities

---

Ulcer

---

Diarrhea

---

Heartburn

---

Sensory   Blurred Vision

---

Nose Bleeds

---

# Adult Intake

Chronic Ear Infections

---

ringing in Ears

---

Sore Throat

---

Loss of Smell

---

Hearing Loss

---

Integumentary    Skin Cancer

---

Rash

---

Acne

---

Psoriasis

---

Bruise Easily

---

Hair Loss

---

Eczema

---

Slow Healing

---

Endocrine    Thyroid Issues

---

Swollen Glands

# Adult Intake

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Low Blood Sugar

---

Immune Disorder

---

Low Energy

---

Frequent Infection

---

Genitourinary    Kidney Stones

---

Prostate Issues

---

Bedwetting

---

Infertility

---

PMS Symptoms

---

General    Fainting

---

Loss of Appetite

---

Sudden Weight Gain

---

Fatigue

---

Loss of Sleep

---



# Adult Intake

Weakness

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Sudden Weight Loss

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## History

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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Surgery/Trauma History   Cancer   Back Surgery   Bypass Surgery   Hernia   Other

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Fractures   Yes   No

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Auto Accident   Yes   No

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Spinal Injury   Yes   No

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Hospitalization   Yes   No

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Alcohol Use   None   Daily   Weekly

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Coffee Use   None   Daily   Weekly

---

Tobacco Use   None   Daily   Weekly

---

Exercise   None   Daily   Weekly

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# Adult Intake

Pain Reliever   None   Daily   Weekly

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Soft Drinks   None   Daily   Weekly

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Water Intake   None   Daily   Weekly

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Family History

Mother Age

---

Age At Death

---

Illness

---

Health                      Good   Bad

Father Age

---

Age At Death

---

Illness

---

Health                      Good   Bad

Sibling Age

---

Age At Death

---

Illness

---

Health                      Good   Bad

Sibling Age

# Adult Intake

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Age At Death

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Illness

---

Health Good Bad

## Finalize

What is the most significant thing you can do to improve your health? \_\_\_\_\_

How committed are you at achieving your maximum health potential



How do you want us to handle your problem? Temporary Relief Maximum Correction

Please Read the following carefully before signing.

Chiropractic care, like all forms of health care, holds certain risks.

While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, very rare occurrence of fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million. The latest research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke.

After careful consideration of the benefits, risks, and alternatives to chiropractic, I do hereby consent to examination and treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

In the instance that x-rays are deemed necessary, I understand that I should alert the doctor if there is a possibility that I may be, or am, pregnant.

\*\*After agreeing, please Sign and Submit

Signature