NP Intake Form

Bruce Street Family Chiropractic
81 Bruce St.
Kitchener, ON N2B 1Y7
(519) 743-6339

Symptoms

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this appointment: ____________________

Have you tried anything to ease this problem? ____________________

At its worst this problem interferes with: your ability to work hobbies/sports family or social time

If you don?t get this problem corrected, do you think it will get worse in the next 5 - 10 years? yes no

On a scale of 1 to 10 (10 being the highest) what is your commitment to getting this problem corrected and improving your health? (Circle)

Very Low Very High

Please check any body signals that have been present in the last 12 - 18 months...

Musc.Skel.Code neck pain/stiffness low back pain pain between shoulders pain or weakness ____________________

cold hands or feet arthritis/swollen joints/bursitis spinal curvature walking problems jaw problems

Imm. Code fever frequent colds bronchitis/pneumonia sinus problems asthma allergies ear infection/tonsillitis

Neuro. Code headaches/migraines dizzy/light-headed/fainting numbness, tingling or weakness loss of sleep convulsions/seizures nervousness/depression poor concentration/memory

Cardio-Vasc-Resp. Code chest pain high blood pressure (Low BP) stroke (T.I.A.) shortness of breath/cough heart problems fatigue/chronic tiredness

Dig. Code nausea/vomiting excessive gas or bloating indigestion/heartburn/ulcer black/bloody stools

NP Intake Form

appetite changes/excessive thirst blood sugar/diabetes constipation diarrhea (Irritable Bowel) colitis
liver/gall bladder trouble hemorrhoids weight change?gain/loss visual disturbance
deafness/hearing problems ears ringing (tinnitus) earaches sore throat (hoarseness) loss of smell/taste
difficulty swallowing thyroid problems

G.U. Code kidney problems/stones problems with urination increase frequency kidney/bladder/prostate
sexual dysfunction infertility

Women Only: menstrual problems excessive cramps/pain irregular cycle menopause breast pain/lumps

Last menst.period:________________________ Pregnant? yes no unsure

What significant health concerns have your family members experienced?

Parents/Siblings ____

Spouse/Partner____

The spine is the most overlooked and neglected part of a child?s health. Do your children suffer from any of the following... (Please circle):

earaches tonsillitis headaches allergies frequent colds (3 or more/year) growing pains asthma
bronchitis bedwetting other

____

By signing here, I verify that the above information is true and accurate regarding my health history.

Signature:

Personal Info

CONFIDENTIAL PATIENT HEALTH RECORD

First Name: ______________________________ Last Name:___________________________

Address:____

City:_____________________________________ Postal Code: ________________________

Home Phone:______________________________ Work Phone:_________________________

Cell Phone: ______________________________ Email address:_______________________

Date of Birth:_____________________________ Age:______________________

Sex: M F Extended Health Insurance? yes no

Occupation:_______________________________ Employer:___________________________

NP Intake Form

Marital Status: married common-law partnered single widowed divorced separated

Spouse?s Name: ______________________________

Do you have children? yes no

____

Have you ever received chiropractic care before? yes no

If yes, approximate date of your last visit: ______________________________

Doctors name: ______________________________

Spinal x-rays taken in the last 12 months? yes no

____

How did you hear about our office? ______________________________

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression.

Our goal is to uncover the layers of injury or damage (especially to your nervous system), that result in lowered health.

Following your consultation, the doctor may recommend a specific course of examinations in order to determine whether you have spinal nerve stress causing interference with your inborn health potential.

LOSS OF WELLNESS

Most health problems are present for years before we are aware of them.

Please complete the following questions asclosely and carefully as possible by checking the appropriate answers:

Your birth process?

Was the delivery: long and/or difficult

____

forceps vacuum extraction caesarean breech?

NP Intake Form

Was your mother given: drugs epidural induced-gel or drip? induced-gel or drip?

Growth and Development?

Were you taught how to care for your spine? yes no

Were you breast fed? yes no

Did you have: childhood falls accidents sports injuries auto accidents

---

Current Health Habits?

Do you smoke? yes no

Do you drink alcohol? yes no

Do you go to the dentist for regular check-ups? (min.yearly) yes no

Do you exercise regularly? yes no

Do you belong to a gym or sports club? yes no

Sleeping Posture: side stomach back restless

# of pillows ______________________ How long do you sleep per night? ______________

Sleep Quality:

Poor Excellent

Rate your stress level on an average day:

Very Low Very High