RHP

New Patient Intake Form

Patient information

DOB(D/M/Y):________

Name:______________________________ Male ❑ Female ❑ Other ❑

Address:___________________City ______________Prov__________Postal______________

Email:______________________________

Phone number: (H)_________________(C)_____________________

Marital status: Single o Married o Occupation:____________________ Age _____

Emergency Contact: (Name)___________________ Phone #____________Relation:__________

Is this condition/injury work related? Yes❑No❑ Other?_________________

Reason for your visit?

____

____

When did it start?________________________

What makes it better ?_____________________Worse?___________________________________

Are you taking anything for this condition ?___________and if so how much ?___________

Have you suffered with this or a similar problem in the past? ❑Yes ❑No ❑ New

If Yes How many times ?______________

Who have you seen for this condition?___________________Did you find it helpful? __________

Past Medical History:

Medical conditions:____
*Past injuries and date:*____
*Medications:(+dosage)*____

Relevant Past Family History:

Father:
Mother:
Siblings:
Other:

Is there anything else we should know about your condition?

Referral

Name of Family Doctor?______________________Location______________________________

Who referred you to Chiropractic ? (check all that applies)

☐ Physiotherapy ☐ Massage Therapy ☐ naturopathy ☐ Psychologist ☐ Occupational therapist

If other, please specify:____

Have you ever been treated previously on the same injury?________________________

And if so by who ?_______________________________

Social Health

How much alcohol do you consume?________________ Frequency?______________

How many cups of coffee do you drink daily?_________________________________

How much soda pop do you consume daily ?__________________________________

How much water do you drink daily?______________________________________

Do you use recreational drugs? Yes ☐ No ☐

Please rate your eating habits where 0 means your eating habits are unhealth and 10 being you eat extremely clean/health.

1 ☐	2☐	3☐	4☐	5☐	6☐	7 ☐	8☐	9 ☐	10☐

What are your typical eating habits ?

☐ Skip breakfast ☐ 2 meals per day ☐ 3 meals a day ☐ Snacking throughout the day

On average how many hours do you sleep at night ?
What is your preferred sleeping position?
On a regular basis how much do you exercise?
What would be the most significant thing you could do to improve your health?
What additional health goals do you have?

On a scale of 0 to 10, where 0 means you have No stress and 10 means a LOT OF STRESS please indicate PHYSICAL stress level.

1 ☐	2☐	3☐	4☐	5☐	6☐	7 ☐	8☐	9 ☐	10☐

On a scale of 0 to 10, where 0 means you have No stress and 10 means a LOT OF STRESS please indicate your EMOTIONAL stress level.

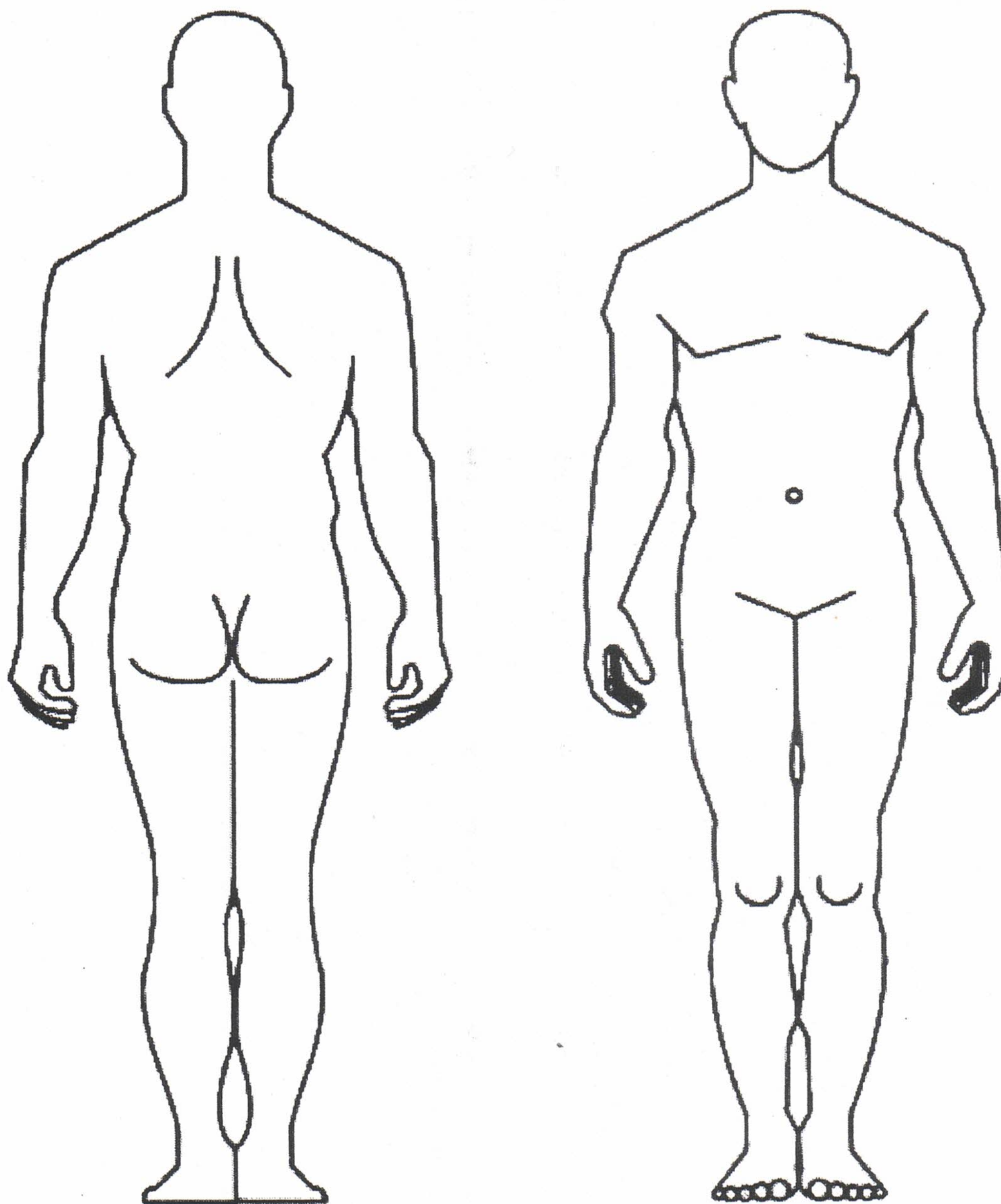
1 ☐	2☐	3☐	4☐	5☐	6☐	7 ☐	8☐	9 ☐	10☐

What are your major stressors in your life ?

RHP

1-Aching
2-Tingling
3-Burning
4-Numbness
5-Other

VAS Scale



Draw the location of your pain on the body outline and mark how intense it is on the pain line below.

No pain ____ Worst pain

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____________ day of__________________________, 20______.

______________________________	______________________________
Patient Signature (Legal Guardian)	**Witness of Signature**
Name:__________________________	**Name:__________________________**
(please print)	**(please print)**