Adult Intake – Ages 13+

Welcome to Complete Health!

This form is to provide your doctor with a detailed health history to better manage your case. Please complete the form to the best of your knowledge.

Email/text notifications

Name: _____ Date: _____

E-mail: _____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail for appointment reminders and information regarding your wellness.

Do you consent? □ YES □ NO _____

Please sign name here

Cancellation Policy

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.
We understand some circumstances are beyond your control, so please discuss with us when cancelling.
No shows will be charged the full treatment amount.

_____

Patient Signature

Personal Information

Date: _____ Alberta Healthcare Number: _____
First Name: _____ Surname: _____ Middle Initial: _____
DOB: _____ Age: _____ □ Male □ Female □ Other
Marital Status: _____ Children: _____ Occupation: _____
Address: _____ City: _____ Postal Code: _____
Phone #: _____ E-mail: _____

Person to Contact in Case of Emergency:
Name: _____ Phone #: _____

How did you hear about Complete Health? _____

Your Health Care Team

Family Doctor: _____ Physiotherapist: _____
Naturopath: _____ Midwife: _____
OB/GYN: _____
Massage Therapist: _____ Other: _____

Have you ever seen a Chiropractor? □ YES □ NO
Who? _____ Date of last adjustment? _____

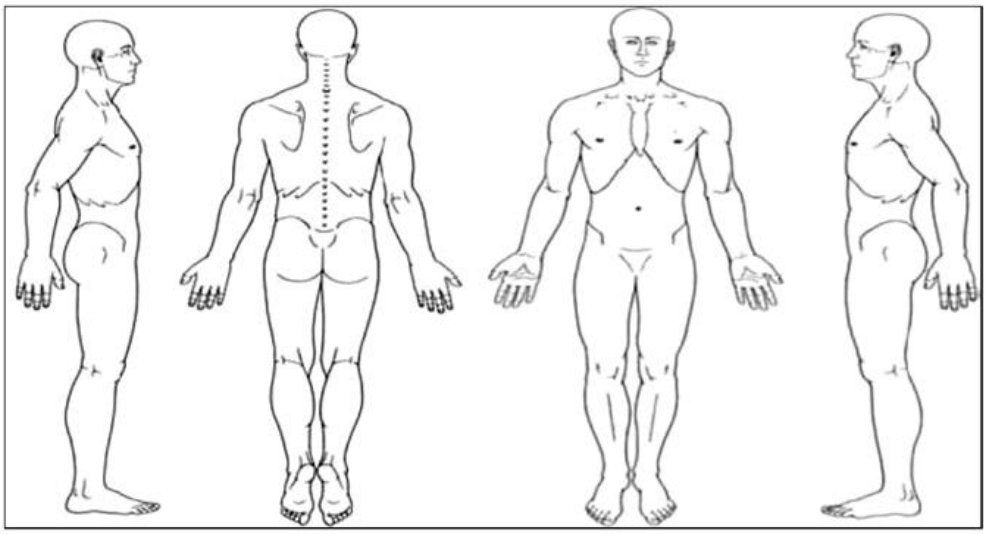
Current Health Condition

Purpose of this appointment: _____
Explain how complaint occurred: _____
When did this condition begin?_____
Condition has persisted for: □ DAYS □ WEEKS □ MONTHS □ YEARS
What activities make this condition better?_____
What activities make this condition worse? _____
Have you seen anyone else for this condition? If so, whom?_____
Are you seeking treatment for a Motor Vehicle Accident? □ YES □ NO
Are you pregnant? □ YES □ NO How many weeks? _____ Due Date: _____
Medications/supplements/vitamins you are taking: _____
_____

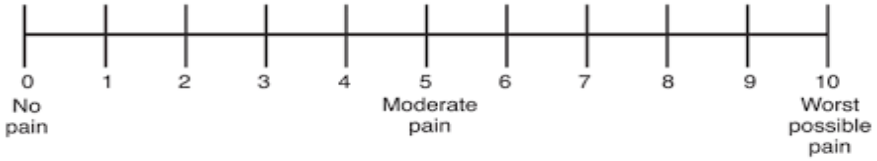
INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U- Unable P- Painful D- Difficult L- Limited N- Normal

___Coughing/Sneezing	**___Kneeling**	**___Balancing**	**___Gripping**
___Pulling	**___Pushing**	**___Reaching**	**___Climbing**
___Sitting	**___Sexual Activity**	**___Sleeping**	**___Dressing Self**
___Standing (more than 1 hr.)	**___Lying on back**	**___Lying flat on stomach**	**___Bending over forward**
___Walking short distances	**___Carrying car seat**	**___Getting in/out of car**	**___Turning over in bed**



RATE YOUR PAIN ON THIS SCALE- Mark with an X



GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and goals when recommending your treatment plan. Please check the type of care desired so that we may have your goals in mind.

□ Relief Care (Symptomatic relief of pain or discomfort)
□ Corrective Care (Corrective relief of pain or discomfort)
□ Preventative Care (Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic)
□ I want the Doctor to select the type of care appropriate for my condition

_____ _____

Patient Signature Date

Health Systems Review Please check each of the following diseases or conditions that you have now or have had in the past

□ Headaches	□ Congenital Heart Defect	□ Ankle Swelling	□ Kidney Problems	□ Arthritis	□ Hepatitis
□ Sinus Problems	□ Heart Surgery/Pacemaker	□ Rheumatic Fever	□ Difficulty Swallowing	□ Motor Vehicle Accident	
□ Cancer	□ Loss of Sleep	□ Chemotherapy	□ Vision Problems	□ Nausea	□ Asthma
□ Shingles	□ Fainting	□ Numbness	□ Thyroid Problems	□ Digestive Problems	
□ Diabetes	□ Low back problems	□ Venereal Disease	□ Excess/Painful Urination	□ Tuberculosis	□ Ulcers/Colitis
□ Heart Attack	□ Stroke	□ HIV/Aids	□ Psychiatric Problems	□ Alcohol/Drug Abuse	
□ Blood Clots	□ High Blood Pressure	□ High Cholesterol			

Surgery: _____

For women:

Infertility Issues	□ YES □ NO	Using birth control	□ YES □ NO
Are you pregnant	□ YES □ NO	Irregular cycles	□ YES □ NO
Are you nursing	□ YES □ NO	Do you experience painful menstruation	□ YES □ NO

Health & Lifestyle Habits

How many fruits/vegetables do you eat per day? □ 0 □ 1-2 □ 3-4 □ 5+

How many glasses of water do you drink each day? □ 0 □ 1-2 □ 3-6 □ 7-10 □ 10+

Do you exercise regularly? □ YES □ NO

HABITS

Caffeine: cups/day: ____

Smoking: packs/day: ___

Drinking: alcohol/wk: ___

Fast Food: meals/wk: ___

Junk Food: items/wk: ___

Sleep: hours/night: _____

Stress: Low Moderate High

DIET

□ Poor

□ Average

□ Organic

□Vegetarian

□ Balanced Meals

□ Gluten/Dairy allergy/sensitivity

STRESS HISTORY

Name your biggest PHYSICAL stressors _____

Name your most significant CHEMICAL and/or NUTRITIONAL stressors_____

Name your largest sources of MENTAL and/or EMOTIONAL stressors _____

List any other source of stress_____

FAMILY HISTORY

□ Cancer _____ □ Diabetes □ Heart Problems □ High Blood Pressure □ Arthritis

□ Multiple Sclerosis □ Depression □ Osteoporosis □ Digestive Issues/Irritable Bowel

□ Adverse Vaccine Reactions □ Stroke

□ Other _____

Additional Notes:

_____

_____

_____

_____

I confirm that the information I have provided in regards to my current condition and past health history is true and complete to the best of my knowledge.

Signature: _____ Date: _____

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