AXIOM CHIRO

INTAKE & HISTORY

TODAY'S DATE _____ *Who may we thank for referring you?* _____

MY PRACTICE MEMBER PROFILE

PRACTICE MEMBER NAME _____
Last Name

_____
First Name *Middle Inital*

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____

SEX *Male / Female / Other* AGE _____ BIRTHDAY _____

ALBERTA HEALTH NUMBER _____

INSURANCE PROVIDER _____

OCCUPATION _____

EMERGENCY CONTACT INFO

NAME _____

RELATIONSHIP _____ PHONE NUMBER _____

MY INJURY & SYMPTOMS

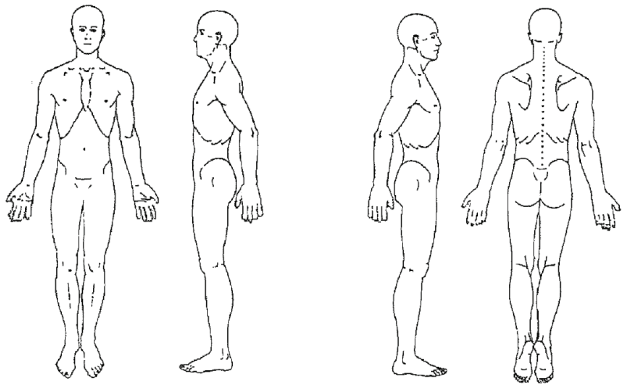
What concerns can we help you with? _____

Is this injury related to an open Workers Compensation (WCB) claim? __ Yes __ No

Is this injury related to a motor vehicle accident? __ Yes __ No

How intense are your symptoms? (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Circle area(s) on the right that are painful (Body Diagram)



What does it feel like? *(Check Boxes)*

__ NUMBNESS
__ TINGLING
__ STIFFNESS
__ DULL
__ ACHING
__ CRAMPING
__ NAGGING
__ SHARP
__ SHOOTING
__ BURNING
__ THROBBING
__ STABBING
__ SWELLING
OTHER: _____

IMPACT OF MY SYMPTOMS

How is this symptom interfering with your life? *(Check Boxes)*

__ MY WORK
__ MY EXERCISE
__ MY RECREATION
__ MY RELATIONSHIPS
__ MY SLEEP
__ MY ESLF-CARE
__ MY eNERGY
__ MY ATTITUDE
__ MY PATIENCE
__ MY PRODUCTIVITY
__ MY CREATIVITY
OTHER: _____

How committed are you to correcting this issue? (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

MY WELLNESS VALUATION

On the diagram above:

What number represents your health today? _____

What number represents your health in one year's time? _____

MY CURRENT CARE TEAM

Have you been adjusted by a chiropractor before? __ Yes __ No

How long were you receiving adjustments? _____

Why did you stop going? _____

Who is your M.D.? (Medical Doctor) _____

Have you ever been hospitalized or had surgery? __ Yes __ No Explain:

Who is your Dentist? _____

Who is your Massage Therapist? _____

Who is your Naturopath / Nutritionist? _____

Who is your Physiotherapist? _____

MY CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Are you currently pregnant? __No __Yes

Health concerns regarding this pregnancy? _____

MY ALLERGIES, MEDICATIONS, SUPPLEMENTS

ALLERGIES *(List)*	**MEDICATIONS** *(List)*	**SUPPLEMENTS** *(List)*

MY UNDERLYING CONDITIONS

Please select any condition that you have, have had, or a direct family member has had.

__ AIDS/HIV
__ ALCOHOLISM
__ ANXIETY
__ ARTERIOSCLEROSIS
__ ARTHRITIS
__ ASTHMA/ALLERGIES
__ LOW BACK PAIN
__ CARDIOVASCULAR ISSUES
__ CANCER
__ CIRCULATION ISSUES
__ CHILDHOOD ILLNESS
__ DEPRESSION
__ DIABETES
__ DIGESTIVE ISSUES *(Constipation / Diarrhea / GERD / IBS)*
__ ELBOW / WRIST / HAND ISSUES
__ ENDOCRINE ISSUES (THYROID)
__ FOOT / ANKLE ISSUES
__ GOUT
__ HEADACHES / MIGRAINES
__ HEART DISEASE
__ HEPATITIS
__ HIP ISSUE
__ IMMUNE ISSUES
__ LYMPHATIC ISSUES
__ MULTIPLE SCLEROSIS
__ NECK PAIN
__ REPRODUCTIVE ISSUES
__ RINGING IN EARS
__ SCOLIOSIS
__ SHOULDER ISSUES
__ STROKE
__ TMJ ISSUES
__ URINARY ISSUES
__ OSTEOPOROSIS
OTHER: _____

MY RECENT CHANGES

__ DEPRESSED
__ FATIGUE
__ IRRITABLE
__ NERVOUSNESS
__ NUMBNESS
__ RUN-DOWN DEELING
__ TINGLING
LOSS OF SLEEP
LOSS OF WEIGHT: __ LBS
WEIGHT GAIN: __ LBS
OTHER: _____

MY LIFESTYLE

NORMAL HRS OF SLEEP: __ PER NIGHT

IN WHAT POSITION DO YOU SLEEP BEST?
__ BACK __ STOMACH __ L SIDE __ R SIDE

WATER: __ LITRES PER DAY

COFFEE: __ CUPS PER DAY

SUGAR: __ GRAMS PER DAY

ALCOHOL: __ DRINKS PER WEEK

CIGARETTES: __ PER DAY

CANNABIS: __ PE DAY

MY MENTAL HEALTH

How would you grade your ability to manage your mental health? **EXCELLENT | GOOD | FAIR | GETTING BETTER | GETTING WORSE**

Do you experience any of the following stressors?

Childhood Stress	__ Past	__ Present	__ Mild	__ Significant
School Stress	__ Past	__ Present	__ Mild	__ Significant
Personal Relationships	__ Past	__ Present	__ Mild	__ Significant
Stress from an Illness	__ Past	__ Present	__ Mild	__ Significant
Work Related Stress	__ Past	__ Present	__ Mild	__ Significant
Change in Lifestyle	__ Past	__ Present	__ Mild	__ Significant
Abuse	__ Past	__ Present	__ Mild	__ Significant

MY PHYSICAL HEALTH

How would you grade your ability to manage your physical health? **EXCELLENT | GOOD | FAIR | GETTING BETTER | GETTING WORSE**

Have you experienced any of the following?

Birth Trauma	__ Past	__ Present	__ Mild	__ Significant
Falls	__ Past	__ Present	__ Mild	__ Significant
Vehicle Accidents	__ Past	__ Present	__ Mild	__ Significant
Work Injuries	__ Past	__ Present	__ Mild	__ Significant
Sports *repetitive or specific incident*	__ Past	__ Present	__ Mild	__ Significant