River North Family Chiropractic

Dr. Terry Kowalke D.C. Dr Lisa Reinfort D.C.

Patient Intake Form

MB Health # (6 Digits): ____________ PHIN # (9 Digits): ____________
Full Name: ____________ Gender: ____________
Date of Birth (MM/DD/YYYY): ____________
Address: ____________ Postal Code: ____________
City/Province: ____________ Phone Number: ____________
Email: ____________ Occupation: ____________
Marital Status: ____________ Significant Others Name: ____________
# of Children: ____________ Children's Names: ____________
Have you had previous chiropractic care? **Yes/No** Chiropractors Name: ____________
Result of past care: **Excellent/Good/Fair/Poor** Last visit? ____________
Please list all medications and supplements: ____________
Common activities at work: **Sitting/Standing/Walking/Lifting/Bending/Other:** ____________
Please list your primary reason for seeking care with us: ____________

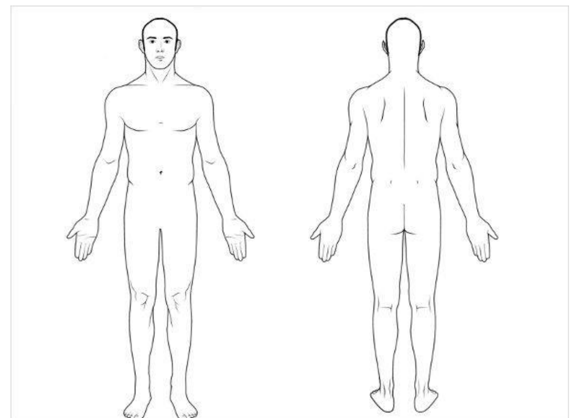
____

How long have you had this? ____________
Is it getting: **Better/Worse/Not Changing** Have you had this in the past? ____________
This interferes with: **Work / Sleep / Exercise / Daily Activity / Other:** ____________
What other treatment have you had for this condition? ____________
Have you missed work or school because of this condition? ____________
On a scale from 0 (no pain) to 10 (worst pain imaginable), please rate your discomfort. Please circle:

1 2 3 4 5 6 7 8 9 10

What does it feel like?

○Numbness	○Radiating
○Tingling	○Burning
○Sharp	○Stabbing
○Stiffness	○Dull
○Aching	○Cramping
○Swelling	○Shooting
○Nagging	○Other: ____________



IMPACT OF YOUR SYMPTOMS

How are the symptoms/conditions interfering with your life?

	None	Mild	Moderate	Severe
Work	○	○	○	○
Exercise	○	○	○	○
Recreation	○	○	○	○
Sleep	○	○	○	○
Self-Care	○	○	○	○
Relationships	○	○	○	○

	None	Mild	Moderate	Severe
Energy	○	○	○	○
Attitude	○	○	○	○
Patience	○	○	○	○
Productivity	○	○	○	○
Creativity	○	○	○	○
Other:				

PLEASE CHECK OFF ANY CONDITIONS YOU HAVE/HAVE HAD: C - CURRENT P - PAST

C	P	MUSCULOSKELETAL	C	P	GASTROINTESTINAL	C	P	EYES/EARS/NOSE/THROAT
○	○	Osteoporosis	○	○	Nausea/Vomiting	○	○	Dizziness
○	○	Joint stiffness	○	○	Heartburn	○	○	Hearing Problems
○	○	Backache	○	○	Diarrhea	○	○	Vision Problems
○	○	Neck Pain	○	○	Constipation	○	○	Bleeding gums
○	○	Muscle Weakness	○	○	Ulcers	○	○	Allergies
○	○	Gout	○	○	Sinus Infection	○	○	Jaw Pain
○	○	Broken Bones	○	○	Hernia	○	○	Frequent colds
○	○	Joint Replacement	○	○	Black/Bloody Stool	○	○	Difficulty Swallowing

C	P	NEUROLOGICAL	C	P	GENITOURINARY	C	P	REPRODUCTIVE
○	○	Headaches	○	○	Frequent Infections	○	○	Irregular Cycle
○	○	Seizures	○	○	Urination Problems	○	○	Painful Menstruation
○	○	Numbness/Weakness	○	○	Blood in Urine	○	○	Excessive Flow
○	○	Concussion	○	○	Kidney Disease	○	○	Menopause
○	○	Anxiety	○	○	Kidney Stones	○	○	Hot Flashes
○	○	Depression	○	○	Prostate Problems	○	○	Miscarriage

C	P	Cardiovascular	C	P	Respiratory
○	○	Fainting	○	○	Asthma
○	○	Heart Disease	○	○	Bronchitis
○	○	High Blood Pressure	○	○	Cough/Wheezing
○	○	Low Blood Pressure	○	○	Emphysema
○	○	Irregular Heartbeat	○	○	Difficulty Breathing
○	○	Poor Circulation	○	○	Pneumonia
○	○	Swelling of Limbs	○	○	Shortness of Breath

If Applicable: Are you pregnant? **YES/NO**
If yes, when is your due date? ______________

Other:
____
____
____
____
____
____

Do you have or have you had any of the following conditions? Please Circle

Aneurysm Cancer Stroke Diabetes Heart Attack Fatigue Bleeding Disorders

Clotting Disorders High Cholesterol Other: ______________________________

Do you have a family history of any of the following? Please Circle.

Cancer Diabetes Heart Attack Stroke Other: ______________________________

Please list any surgeries and/or serious injuries/illness/vehicular accidents: ______________________________

Please list any allergies: ______________________________

Is there anything else your provider should know regarding your conditions and/or personal health?

Please let us know how you heard about our office:

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) **Signature of Witness/Doctor**

Patient's Name:_________________________ **Doctor's Name:__________________________**
(please print) **(please print)**

CCPA12.08 (ENGLISH)