Active Life Physiotherapy Centre
10 Bur Oak Ave. Unit 2A.
Markham, ON. L6C 0A2

Chiropractic Patient Intake Form

First Name: Last Name: Date of Birth: d-- /m-- /y----

Primary Phone #: Secondary Phone #:

Address: Email:

Occupation: How Did You Hear About Us?

Emergency Contact: Name: Phone #: Relationship:

Have you had chiropractic treatment before: Yes/No

Please indicate the area on the diagram which best presents the pain(s) or sensation(s) you are currently experiencing.

Numbness:

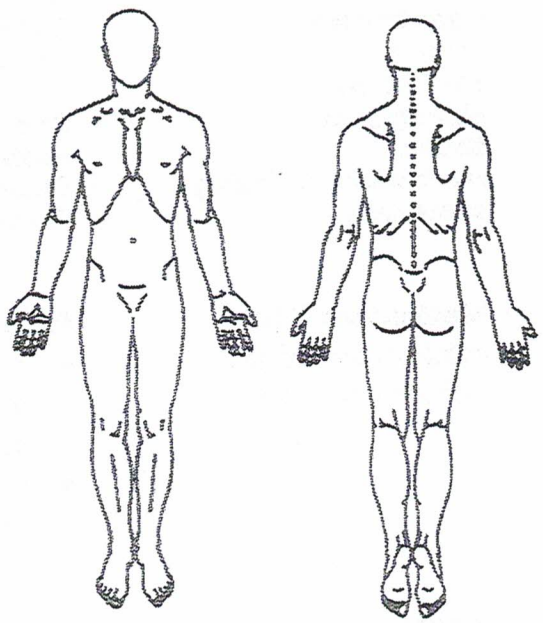
Burning: X X X X X X X X X X X X

Dull/Achy: + + + + + + + + + + + +

Pins/Needles:

Stabbing/Sharp:

Stiff & Tight: 2 2 2 2 2 2 2 2 2 2 2 2



R Front L L Back R

Please **circle** for any conditions or symptoms currently causing you problems.

Please use ✓ for any conditions or symptoms that you had in the past.

General Symptoms
Osteoporosis
Loss of Consciousness
Night Pain
Blackout
Headache
Night Sweats
Loss of Weight
Excess Sweating

Muscles and Joints
Low Back Pian
Mid Back Pain
Neck Pain
Headache
Painful Tailbone
Shoulder Pain
Arm/forearm Pain
Elbow Pain
Wrist/Hand Pain
Hip Pain
Knee Pain
Ankle/Foot Trouble
Arthritis
Sore/Stiff Neck
Loss of Strength

Cardiovascular
High Blood Pressure
Low Blood Pressure
Congestive Heart Failure
Heart Attack
Stroke/CVA
Varicose Vein

Gentourinary
Frequent Urinating
Bed Wetting
Prostate Trouble
Kidney Infection
Blood in Urine
Trouble Urinating

Neurologic
Dizziness
Problem Swallowing
Problem speaking
Vison Problem
Vision loss
Ear Problems
Hearing Loss
fainting
Numbness and Tingling
clumsiness

Respiratory
Asthma
Chronic Cough
Spitting up Blood
Spitting up Phlegm
Difficulty Breathing

Skin
Rashes/ Itching
Bruise Easy
Dryness

Gastrointestinal
Ulcer
Gall Bladder Trouble
Hemorrhoids
Constipation
Vomiting
Blenching or Gas
Excess Hunger
Poor Appetite
Diabetes

Medications: What medications are you currently on, if any?

For women only:

- Are you pregnant? Yes/No (If yes, when are you due:
- Currently on Birth Control?

I hereby consent to a consultation as well as a physical examination relating to my primary condition, as well as minor conditions. If necessary, I also consent to a requisition of diagnosis radiographs (X-ray).

Name: Date: Signature