ActiveLiving chiropractic

p: 250.448.8008
f: 250.448.7428

565 Osprey Avenue
Kelowna, BC V1Y 5A7
www.kelowna-chiro.com

Acupuncture Intake

Name _____ **Phone** (home) _____

Birthdate _____(month / day / year) (cell) _____

Address _____ (work) _____

_____ **Email** _____

Postal Code _____ **Occupation** _____

How did you hear about our clinic? □Friend:_____

□Yellow Pages □Sign □Website □Other:_____

Do you currently wear orthotics? □Yes □No

Are you interested in gait analysis? □Yes □No

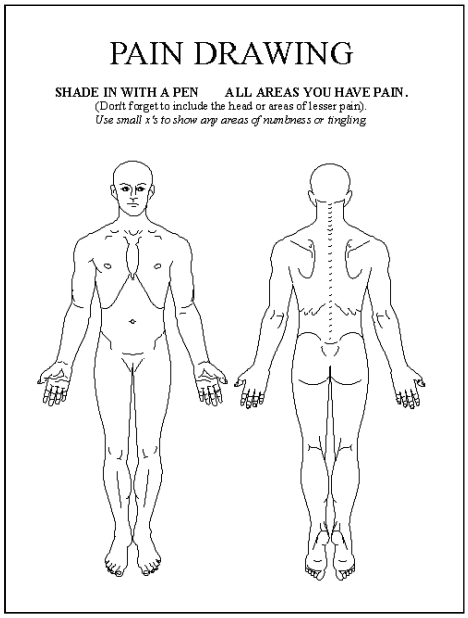
Care Card # _____

Extended Medical Insurer _____

ICBC or **WCB?** **No** **Yes** Claim#

(if active claim, please inform Practitioner as you will need to fill out the related Claim Form)

CURRENT CONDITION:



Please describe your current condition & symptoms:_____

_____

How long have you had this condition/symptom?_____

Have you had this condition before? YES NO **When**?:_____

What makes it **better** (positions/activities/movements)?_____

What makes it **worse(**positions/activities/movements)?_____

What % of each day does it **bother you**? (Circle one)

0% 25%(Intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does this **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Please mark on the line, the pain level that most accurately represents your pain for **each** body area:

	0	1	2	3	4	5	6	7	8	9	10	
Average pain:	No pain	|	|	|	|	|	|	|	|	|	|	Unbearable

GOALS FOR CARE: Check all that apply

□ RELIEF I want to feel better for the least amount of my time and money.
□ MAINTENANCE I want to preserve the progress I've made
□ PREVENTION I want to avoid losing my health
□ WELLNESS I want to be all that I can be; high quality performance, sleep, energy, immune system, maximum brain power and more.

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PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ☐ **Recent accident** such as a fall, whiplash, or blow to the head
- ☐ Spinal/back/neck problems
- ☐ Muscle spasms
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Arm, shoulder, elbow or hand problem
- ☐ Leg, hip, knee or foot problem

MENTAL EMOTIONAL

- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty with stress
- ☐ Worry
- ☐ Irritability/anger
- ☐ Racing thoughts
- ☐ Chest tightness
- ☐ Panic attacks
- ☐ Poor memory
- ☐ Difficulty concentrating

SLEEP

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Waking, with trouble falling back to sleep. What time? ____
- ☐ Over thinking or racing thoughts
- ☐ Dream Disturbed sleep

RESPIRATORY

- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Cough
- ☐ Bronchitis/pneumonia
- ☐ Excessive mucus

CARDIOVASCULAR

- ☐ Cold hands and/or feet
- ☐ High blood pressure
- ☐ Low blood pressure.
- ☐ Swelling of ankles/feet/hands
- ☐ Blood clots
- ☐ Fainting

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Sinus problems
- ☐ Headaches or migraines
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Dizziness or vertigo
- ☐ Jaw or mouth problem

SKIN AND HAIR CONDITIONS

- ☐ Loss of hair
- ☐ Dry skin
- ☐ Rashes
- ☐ ulcerations
- ☐ itching
- ☐ eczema
- ☐ pimples

FLUID METABOLISM & URINATION

- ☐ Spontaneous Sweating
- ☐ Night sweating
- ☐ Yellow sweating
- ☐ Cloudy urination
- ☐ Burning urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Difficulty holding urine
- ☐ Difficult urination
- ☐ Decrease in flow

GASTROINTESTINAL

- ☐ Constipation
- ☐ Loose stool
- ☐ Hard stool
- ☐ Sticky stool
- ☐ Blood in stool
- ☐ Gas
- ☐ Bloating
- ☐ Cramping
- ☐ Pellet-like stools
- ☐ irregular
- ☐ heart burn/acid reflux
- ☐ belching
- ☐ loss of appetite
- ☐ excessive hunger
- ☐ nausea

FEMALE REPRODUCTIVE

- ☐ Regular periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Heavy menstruation
- ☐ Clotting in menstruation
- ☐ Color of blood _____

PMS SYMPTOMS

- ☐ Abdominal bloating
- ☐ cramping
- ☐ Irritability/anger
- ☐ Breast tenderness
- ☐ Sweet cravings
- ☐ Forgetfulness
- ☐ Insomnia
- ☐ Other: _____

YOUR LIFESTYLE

Height_____ **Weight**_____Has your **weight** changed recently? Gained____ Lost___ No change ___

How many **hours of sleep**_____
Sleep position: Side Front Back
Quality of sleep: Poor Moderate Excellent
Do you drink **Alcohol**?_____drinks/day
Grind your teeth/clench? No Yes
How many **hours do you sit**? _____/day

Diet: Poor Moderate Excellent
Would you like advice? No Yes
Do you **Smoke**: No Yes _____cigs/day
Exercise: No Yes, _____/week
Gym/Cardio Weights Core
Yoga Pilates Bootcamp Crossfit
Swimming Biking Running Other

For Women: Are you pregnant? □Yes □No Date of Last Period_____

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Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal/work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**:_____

_____

_____

Please list any Medications you presently take AND what condition you are taking them for:

_____

Current supplements and **Why** you are taking them:

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

TREATMENT HISTORY:

	Name/Location	Date of last visit	Years of Care or # of treatments	Result of Treatment	Comments
Massage Therapy				Excellent Good Fair Poor	
Chiropractor				Excellent Good Fair Poor	
Physiotherapy				Excellent Good Fair Poor	
Naturopath				Excellent Good Fair Poor	
Acupuncture				Excellent Good Fair Poor	
Other (specify)				Excellent Good Fair Poor	

Your **Medical Practitioner's** Name:_____ Phone:_____
Date last seen _____ Reason for visit _____ Recent medical testing: Xrays___ Blood test ____ Other____
Permission to contact your medical doctor (Signature) _____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated Practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated Practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**