www.wakewellness.ca
(705) 245-9253
Info@wakewellness.ca

New Patient Intake Form

Name:_____ **Date:**_____

Home Phone #:_____ **Work Phone #:**_____

Home Address:_____ **City:**_____ **Postal Code:**_____

Medical Doctor:_____ **Email Address:**_____

Gender: Male_____ **Female**_____ **Age:**_____ **Birth Date:**_____

Marital Status: (circle one) M S W D **Spouse's Name:**_____

Children's Names and Ages:_____

Occupation:_____ **Work Activity:** ____Sitting ____Standing ____Manual labour

Do you have Extended Health Care? N or Y: ____Chiropractic ____Orthotics ___Massage ___Acupuncture

How did you hear about our clinic? ____Referral ____Doctor ____Website ____Advertising ____Other

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Present Complaint

Are you here because of: work related injury Yes____ No____ Auto accident Yes____ No____

What is your presenting complaint? Where do you feel the problem?

_____

_____

When did this start?_____ **How did it start?**_____

Have you had this similar condition before? N or Y:_____

How bad is your pain/ache? (circle one) 0 1 2 3 4 5 6 7 8 9 10 (0 - no pain & 10 - most pain)

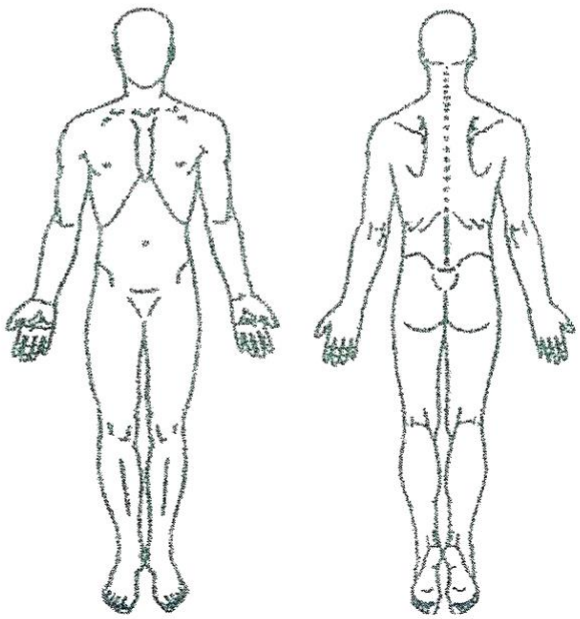
How frequent is your problem? ____constant ____frequent ____occasional ____comes & goes

What activities aggravate your condition?_____

Do you feel your condition is getting: ____worse ____better ____no change

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P – pain
N – numbness
W – weakness
S – shooting
A - aching



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Have you ever been to a chiropractor before? ____No ____Yes (name):_____

List previous treatments you have received for this present condition:_____

Do you smoke? ____No ____Yes **Do you exercise?** ____No ____Yes (activities):_____

Rate your sleep, hours per night: < 4 4 – 6 6 – 8 8 – 10 12+

Rate your diet: Poor Fair Medium Good Excellent

Please list all medications you are currently taking:_____

Please list any surgeries and operations:_____

Please list any family medical conditions: (Ie. Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

_____

Please view carefully, and indicate if you have experienced any of the following symptoms with an X.

General	**Eyes, Ears, Nose, Throat**	**Genito-Urinary**
_____ Chills	_____ Deafness	_____ Blood in urine
_____ Convulsions	_____ Ear aches	_____ Frequent urination
_____ Dizziness	_____ Ear ringing	_____ Loss of control
_____ Fainting	_____ Sinus infection	_____ Kidney infection
_____ Headaches	_____ Enlarged Glands	_____ Bed wetting
_____ Loss of Sleep	_____ Enlarged Thyroid	
_____ Nervousness	_____ Sore throat	**Pain or Numbness in**
_____ Depression	_____ Tonsillitis	_____ Arms
_____ Neuralgia	_____ Eye pain	_____ Hands
_____ Numbness	_____ Hay fever	_____ Hips
_____ Sweats	_____ Hoarseness	_____ Legs
_____ Loss of weight	_____ Nosebleeds	_____ Knees
_____ Tremors		_____ Ankles
_____ Allergy	**Cardiovascular**	_____Painful tail bone
_____ Fibromyalgia	_____ Rapid heart beat	_____ Sciatica
	_____ Slow heart beat	_____ Shoulders
Muscle and Joint	_____ Swelling of ankles	
_____ Bursitis	_____ Hardening of arteries	**Gastro intestinal**
_____ Foot Trouble	_____ Pain over heart	_____ Excessive hunger
_____ Hernia	_____ Heart attack	_____ burping or gas
_____ Low back pain	_____ Stroke	_____ Colitis
_____ Neck pain	_____ High Blood Pressure	_____ Constipation
_____ Arthritis	_____ Low Blood Pressure	_____ Diarrhea
_____ Osteoporosis	_____ Poor circulation	_____ Stomach pain
_____ Swollen Joints		_____ Nausea
	Skin	_____Vomiting
Respiratory	_____ Bruise easily	_____ Poor appetite
_____ Chest pain	_____ Hives or allergy	
_____ Chronic cough	_____ Itching	
_____ Wheezing	_____ Varicose Veins	
_____ Asthma		

Dr. Initial:_____ Patient initial:_____