Bluebird
SPORT & SPINE

INTAKE FORM

PERSONAL INFORMATION **Date:** _____

Name: _____ ☐ Female ☐ Male ☐ Other **Care Card #** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Telephone: **Home:** _____ **Work:** _____ **Cell:** _____

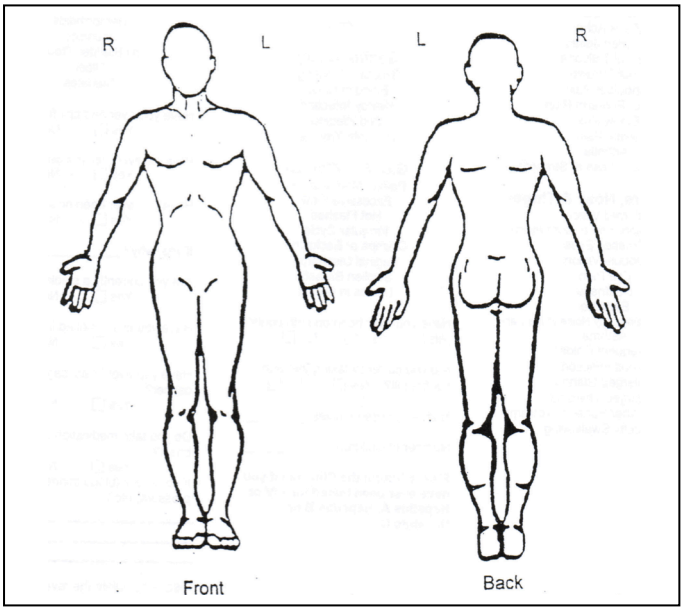
Email: _____ **Birth Date:** _____
Day Month Year

Occupation: _____

Emergency contact: Name: _____

Phone: _____

Appointment reminder:
☐ Email
☐ Text message (Who is your cell phone provider? Bell, Rogers, etc.) _____
How did you hear about us? _____



Please use the diagram at right to indicate the following:

Numbness:	**====**	**Sharp/stabbing:**	**sssss**
Pins & Needles:	**oooo**	**Dull/aching:**	**>>>>**
Burning:	**xxxxx**	**Stiff/tight:**	**2222**

Using the scale, please indicate the severity of your *current* pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN **EXTREME PAIN**

Reason for appointment: _____ **When did this begin?** _____

How did this occur? _____

Have you ever had similar problems? ☐ Yes ☐ No _____

Has the condition ☐ improved ☐ worsened ☐ remained unchanged **since it began?**

Is this condition related to: **Work?** ☐ Yes ☐No **Has your employer been notified?** ☐ Yes ☐ No

Motor vehicle accident? ☐Yes ☐ No **Date of accident:** _____

Claim #: _____ **Adjuster:** _____

Patient Name:_____ Date:_____

What have you done to help with this condition? _____

Have you had X-rays or other tests (MRI, CT, Ultrasound, blood work etc.) for this condition? ☐ **Yes** ☐ **No**

What tests and when?_____

Can you perform your daily home activities?	☐ **Yes**	☐ **Yes, only with help**	☐ **Not at all**
Can you perform your daily work activities?	☐ **All activities**	☐ **Only some**	☐ **Not at all**
Describe your stress level:	☐ **None/mild**	☐ **Moderate**	☐ **High**
Do you exercise?	☐ **Daily**	☐ **Occasionally**	☐ **Not at all**

Circle the word that best describes the way you feel about your general health:

Excellent Good Acceptable Poor Very poor

What do you hope to achieve from this visit? Check all that apply.

☐ **Pain relief** ☐ **Explanation of your condition** ☐ **Exercise to prevent recurrence**

☐ **Performance care** ☐ **Wellness/maintenance care** ☐ **Other:**_____

Have you had any fractures or dislocations?	☐ **Yes**	☐ **No**	**Body part(s):**_____	**Date:**_____
Have you ever been in a car accident?	☐ **Yes**	☐ **No**	**Details:**_____	**Date:**_____
Have you ever been hospitalized?	☐ **Yes**	☐ **No**	**Why?**_____	**Date:**_____
Have you had previous chiropractic care?	☐ **Yes**	☐ **No**	**Doctor:**_____	**Date:**_____

Please list any previous surgeries, illnesses or injuries:_____

_____

List all medications: (prescriptions, vitamins, herbal supplements, birth control, Aspirin, Advil, Tylenol etc.)

_____

List all known allergies:_____

Have *<u>you</u>* or a *<u>family member</u>* ever been diagnosed with or told you have any of the following?

High blood pressure	☐ Yes	☐ No	☐ Family_____
Hardening of the arteries	☐ Yes	☐ No	☐ Family_____
Heart or blood disease	☐ Yes	☐ No	☐ Family_____
Diabetes	☐ Yes	☐ No	☐ Family_____
Tuberculosis	☐ Yes	☐ No	☐ Family_____
Stroke	☐ Yes	☐ No	☐ Family_____
Cancer	☐ Yes	☐ No	☐ Family_____
Osteoporosis (low bone density)	☐ Yes	☐ No	☐ Family_____
HIV/AIDS	☐ Yes	☐ No	
Hepatitis A/B/C	☐ Yes	☐ No	

Are you currently a smoker?	☐ Yes	☐ No	Amount:_____
Did you smoke previously?	☐ Yes	☐ No	Years:_____
Average alcohol intake	_____ drinks/day		
Average caffeine intake	_____coffee/tea/pop per day		
Current sleep quality	Poor 1 2 3 4 5 Good		

Patient Name:_____ Date:_____

HEALTH STATUS SURVEY

Please circle any conditions that are *presently* causing you a problem and underline those that have caused you problems in the past.

GENERAL SYMPTOMS	SKIN	GENITOURINARY
Fever	Rashes	Frequent urination
Excess sweating/night sweats	Itching	Painful urination
Loss of consciousness	Dryness	Blood in urine
Headache	Easy bruising	Kidney infection
Fatigue	Boils	Prostate trouble
Nervousness	Hives (allergies)	Trouble starting flow
Weight loss	Changes in moles or skin markings (size, color,	Uncontrollable urine flow
Night pain	borders, elevation, bleeding)	Bedwetting
Loss of sleep		

NEUROLOGICAL	CARDIOVASCULAR	RESPIRATORY	GENITOURINARY FOR WOMEN
Visual disturbances (blurred, double)	High blood pressure	Asthma	Painful menstruation
Dizziness	Low blood pressure	Chronic cough	Excessive flow
Fainting	Bleeding disorder	Spitting up phlegm	Hot flashes
Convulsions	Stroke	Spitting up blood	Irregular/absent cycle
Problem speaking	Hardened arteries	Chest pain	Cramping/backache
Problem swallowing	Heart/blood disease	Wheezing	Vaginal discharge
Numbness or tingling	Palpitations	Difficulty breathing	Nipple discharge
Clumsiness	Angina	Shortness of breath	Swollen breasts
Weakness	Poor circulation		Lumps in breast
	Swelling of ankles		Menopausal symptoms
	Varicose veins		Pregnancy complications/miscarriage
			Pregnant? Y / N Week?

EYES/EARS/NOSE/THROAT	MUSCLE & JOINT	GASTROINTESTINAL
Failing vision	Neck pain	Poor appetite
Eye pain	Back pain	Indigestion/heartburn
Failing hearing	Tailbone pain	Excess hunger
Earache	Shoulder pain	Belching/gas
Ring/buzz in ears	Arm/forearm/elbow pain	Nausea/vomiting
Frequent colds	Wrist/hand pain	Constipation
Sinus infection	Hip/leg pain	Diarrhea
Enlarged thyroid	Knee pain	Hemorrhoids (piles)
Enlarged glands	Ankle/foot pain	Blood in stool
Hoarseness	Swollen joints	Gallbladder trouble
Nasal drainage	Spinal curvature	Jaundice
Nosebleeds	Arthritis	Ulcer

WRITTEN CONSENT TO NOTIFY FAMILY PHYSICIAN OF CHIROPRACTIC CARE

At Bluebird Sport & Spine, we strive to maintain open communication and professional relationships with other health care providers. In order to provide updates to your family doctor regarding your care, we need to obtain written consent from you as our patient. Please fill in the information below so we can inform your doctor about your diagnosis, treatment, and progress at our clinic.

Dated this ____day of_____, 20____.

Family Physician's Name: _____ **Phone:** _____

Patient Signature: _____ **Witness Signature:** _____

Patient Name: _____ **Witness Name:** _____

(please print) **(please print)**