404 HEALTH CENTRE
CHIROPRACTIC INTAKE FORM

Instructions: Please fill out ALL THREE PAGES. Please also read through the informed consent form. Please discuss this with the chiropractor before signing.

DATE: _____

NAME: _____
first middle last

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE:
RES: _____ CELL: _____ BUS: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: (mm/dd/yyyy) _____

HEALTH CARD NUMBER: _____

OCCUPATION: _____

FAMILY PHYSICIAN AND PHONE NUMBER: _____

_____

Is This a WSIB Claim? yes no

Is This a Motor Vehicle Accident Case? yes no

Dr. Bailey has my consent to review available imaging results (x-ray, ultrasound, MRI etc)?
Yes No Signature _____

Dr. Bailey has my consent to discuss my case with my family doctor?
Yes No Signature _____

PLEASE LIST MEDICATIONS: _____

_____

How Were You Referred To This Office?: _____

Health Status Survey

Name: _____ Date: _____

Please X the box for an conditions or symptoms **presently** causing you problems
Please check (√) the box for those conditions or symptoms you have had in the **past**

GENERAL		**RESPIRATORY**	**SKIN**
□ Loss of consciousness		□ Asthma	□ Rashes/itching
□ Headache		□ Chronic cough	□ Bruise easily
□ Fever		□ Spitting up phlegm	□ Dryness
□ Excess sweating		□ Spitting up blood	□ Boils
□ Night sweats		□ Difficulty breathing	□ Hives (allergies)
□ Weight loss		**CARDIOVASCULAR**	**GASTROINTESTINAL**
□ Night pain		□ Bleeding disorder	□ Poor appetite
□ Generalized pain		□ High blood pressure	□ Indigestion
□ Convulsions		□ Chest pain	□ Excess hunger
NEUROLOGIC		□ Stroke	□ Belching or gas
□ Dizziness		□ Varicose veins	□ Vomiting
□ Problem speaking		□ Swelling of the ankles	□ Pain over stomach
□ Problem swallowing		□ Poor circulation	□ Constipation
□ Blurred/double vision		□ Angina	□ Diarrhea
□ Nausea		**GENITOURINARY**	□ Gall bladder trouble
□ Clumsiness		□ Trouble urinating	□ Ulcer
□ Numbness/tingling		□ Blood in urine	□ Diabetes
MUSCLES & JOINTS		□ Kidney infection	Are you currently a smoker? Y□ N□
□ Sore/stiff neck		□ Prostate trouble	Did you smoke previously? Y□ N□
□ Mid back ache		**GU FOR WOMEN**	Have you been diagnosed with:
□ Low back ache		□ Painful menstruation	Cancer Y□ N□
□ Shoulder pain		□ Excessive flow	HIV/AIDS Y□ N□
□ Arm/forearm pain		□ Hot flashes	Hep A/B/C Y□ N□
□ Elbow pain		□ Cramping/backache	Currently on birth control? Y□ N□
□ Wrist/hand pain		□ Swollen breasts	Previously on birth control? Y□ N□
□ Hip pain		□ Lumps in breasts	# of pregnancies:
□ Knee pain		**ENT**	# of children:
□ Ankle/foot pain		□ Failing vision/eye pain	
□ Arthritis		□ Failing hearing/earache	
		□ Ring/Buzz in ears	
		□ Enlarged thyroid/glands	
		□ Sinus infection	

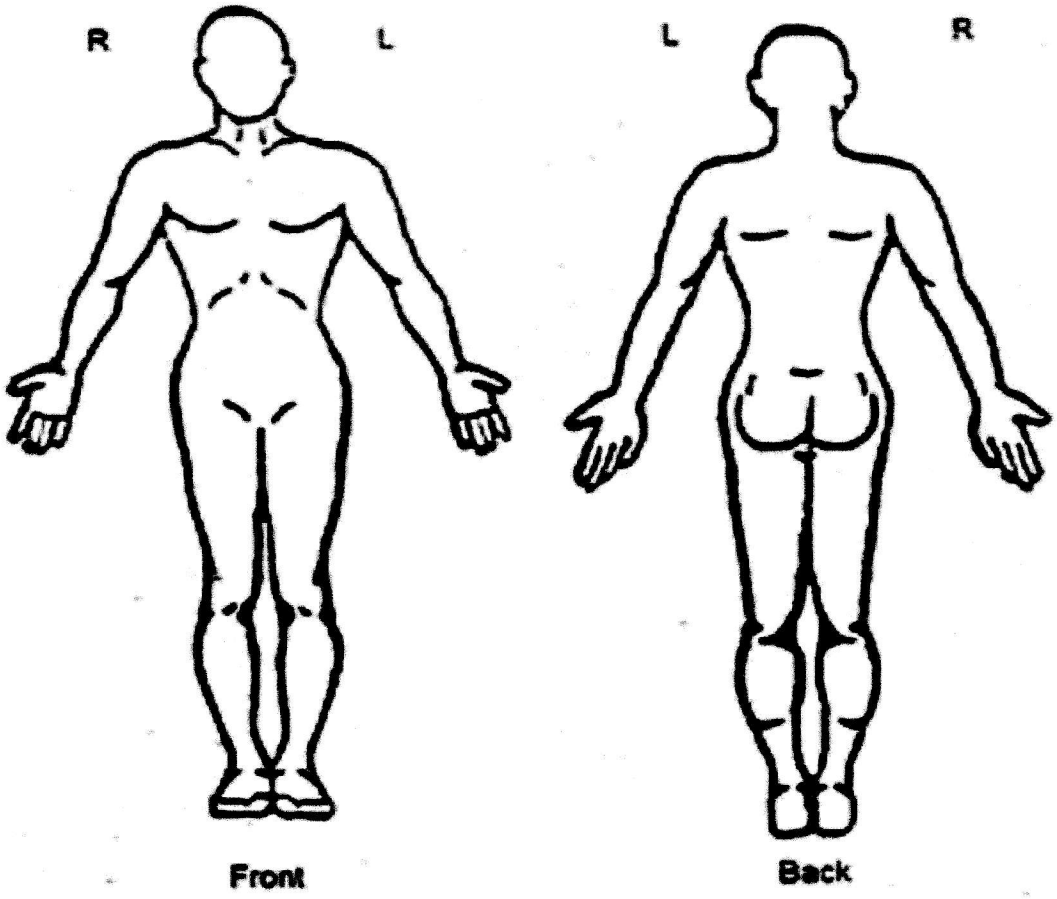
SYMPTOM DIAGRAM

Name: _____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation (s) you are experiencing. Please include **all** areas. Please draw a face on the diagram. Use the symbols provided below.

Symbols:

Numbness	=====	Pins and Needles	ooooo
Burning	xxxxx	Stabbing & Sharp	^^^^^
Dull and Aching	ΔΔΔΔΔ	Stiff and Tight	22222



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature