

CLINIC NAME
ADDRESS

DATE

Participant Information

First Name Last Name

Date of Birth (mm/dd/yyyy) Phone Number Gender

Address Postal code

Email Address Preferred method of contact:

Marital Status: Name of Partner:

Family Physician/NP: Is it ok to send your physician/NP updates regarding your condition?

Have you seen a chiropractor before? If yes, name of chiropractor
If yes, how long ago?

Are you receiving any other treatments for this problem?

Current Medications:

Health2Work Intake form

Previous X-rays or other imaging?

Yes No

If yes, when and where were they taken?

Have you had any recent blood work?

Yes No

Results:

Approximate date of your last physical examination:

Results:

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Within the past 6 months:

Have you had any infections and/or fever?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you had any weight gain or loss?

Exercise:

None	Moderate	Daily
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Packs/day: <input type="text"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drinks/day: <input type="text"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Do you smoke?

Do you drink alcohol?

Do you use recreational drugs?

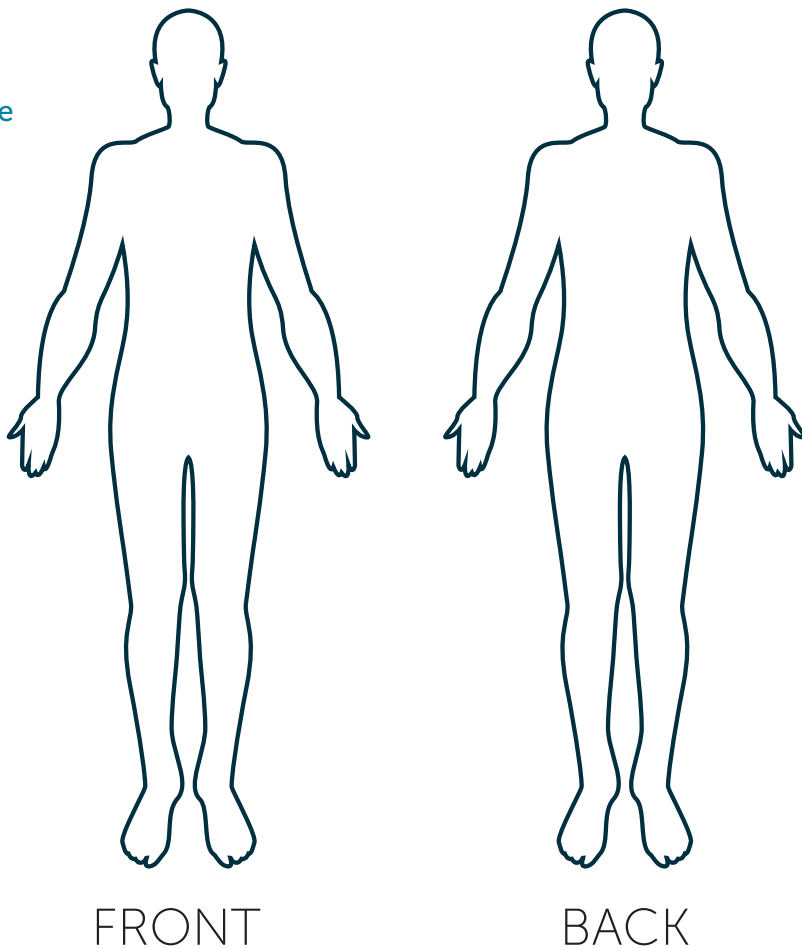
Approximate body weight:

Current Sports:

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Please draw the symbols below that describe your discomfort on the corresponding area of the body (where you feel the symptoms) on the included diagram.

- +++++ Dull and Aching
- ===== Stabbing or Sharp
- //////////////////// Stiff and Tight
- XXXXXXXXXXXXXXXXXX Burning



Have you had any of the following diseases?

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pleurisy
<input type="checkbox"/> AIDS
<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Polio
<input type="checkbox"/> Measles
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> STD/venereal disease | <input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Influenza
<input type="checkbox"/> Eczema | <input type="checkbox"/> Other
<div style="border: 1px solid black; height: 150px; width: 100%; margin-top: 5px;"></div> |
|--|--|---|

Have you ever been in a motor vehicle accident?	Yes	No	Date	
Have you ever had any broken bones/fractures?	Yes	No	When and Type?	
Have you ever been hospitalized?	Yes	No	Date	

Family History of:

- Diabetes
 Cancer
 Back Problems
 Heart Disease

Please read the following list carefully. Circle the symptoms you currently have and place a check mark beside symptoms you have had in the past.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Confusion | <input type="checkbox"/> Colon problems | <input type="checkbox"/> Nose bleeding |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Depression | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Nose discharge |
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arm problems | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Sore gums |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Excessive weight loss | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Coughing phlegm | <input type="checkbox"/> Obesity | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Female Only |
| <input type="checkbox"/> Weak muscles | <input type="checkbox"/> Slow heartbeat | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Previous miscarriage |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Discoloured urine | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Painful menstrual periods |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Breast pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Eye inflammation | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Earache | <input type="checkbox"/> Irregular cycles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting food | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Length of time since beginning of last menstrual period: |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Ear discharge | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Sinus infection | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diarrhea | | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation | | |