Health 2 Work

OW ID#

Health2Work Intake form

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:

Physician/NP:

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

☐ Yes ☐ No

Have you seen a chiropractor before?

☐ Yes ☐ No

If yes, Name of chiropractor

If Yes, how long ago?

Are you receiving any other treatments for this problem?

☐ Yes ☐ No

Current Medications:

Ontario Chiropractic Association

Region of Waterloo COMMUNITY SERVICES

Langs Community. Health. Wellness.

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:

Within the past 6 months:

Have you had any infections and/or fever? Yes☐ No☐

Have you had any weight gain or loss? Yes☐ No☐

Exercise:	☐ None	☐ Moderate	☐ Daily	
Do you smoke?	☐ Yes	☐ No	Packs/day:	
Do you drink alcohol?	☐ Yes	☐ No	Drinks/day:	
Do you use recreational drugs?	☐ Yes	☐ No		
Approximate body weight:				
Current Sports:				

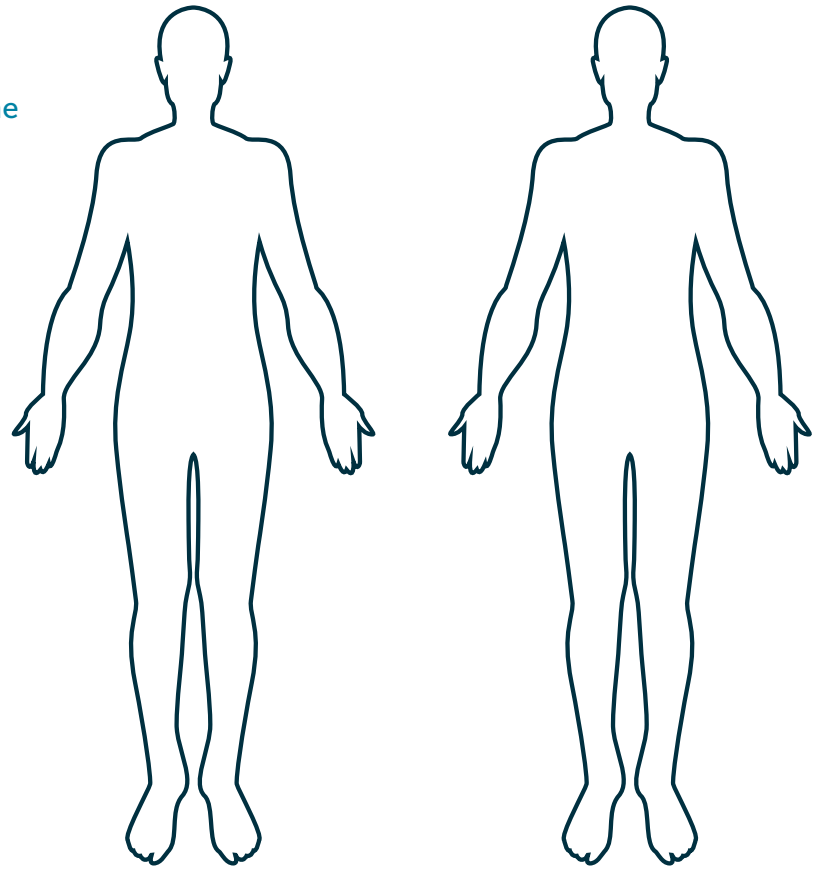
Please draw the symbols below that describe your discomfort on the corresponding area of the body (where you feel the symptoms) on the included diagram.

++++++++++++++ Dull and Aching

Stabbing or Sharp

Stiff and Tight

XXXXXXXXXXXXXX Burning



Have you had any of the following diseases?

- ☐ Cancer
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Diabetes
- ☐ Pleurisy
- ☐ AIDS
- ☐ Appendicitis
- ☐ Polio
- ☐ Measles
- ☐ Heart Disease
- ☐ STD/venereal disease
- ☐ Mental Disorder
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Thyroid Disorder
- ☐ Epilepsy
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Whooping Cough
- ☐ Chicken Pox
- ☐ Influenza
- ☐ Eczema
- ☐ Other

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.

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