



Life 'n Balance WELLNESS CENTRE

Chiropractic Intake Form

How did you hear about Life 'n Balance? _____

Name: _____ Gender: _____ Occupation: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____ Postal Code: _____

Email: _____ Date of Birth: _____

Alberta Health Care #: _____ Are you here for a WCB Case? _____

Emergency Contact (name and number): _____


The following information will be used to help plan safe and effective chiropractic treatment. Please answer the questions to the best of your knowledge.

1. What health goals would you like to achieve?
 - () Pain relief – Focus on relieving pain and control of symptoms
 - () Rehabilitation – Focus on restoring strength and function
 - () Prevention – Focus on avoiding pain episodes and injury
 - () Other - _____
2. Please indicate the area on the provided diagrams which best represents the pain(s) and or sensation(s) you are currently experiencing. Please include all areas and use the symbols provided below.

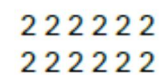
Numbness: 

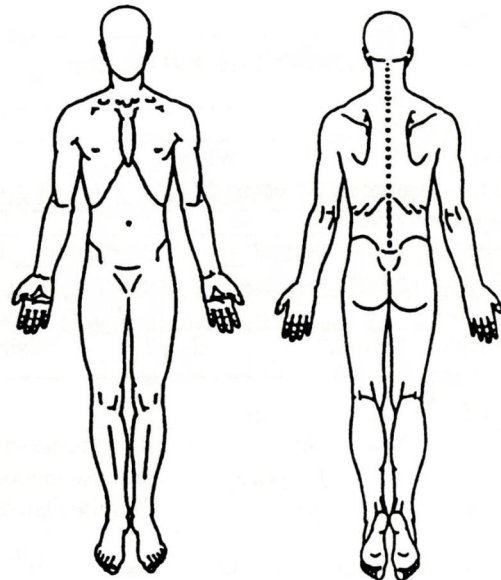
Burning: 

Dull/Achy: 

Pins/Needles: 

Stabbing/Sharp: 

Stiff & Tight: 



R Front L L Back R

3. Have you visited a chiropractor before? If yes, what area was treated? _____
How were the results? Good (), Fair (), Poor ()

Please Flip Over

Please **circle** any conditions or symptoms which are **presently causing you problems**.
 Please **check** any conditions or symptoms which have been **problems to you in the past**.

General
 Osteoporosis
 Loss of consciousness
 Cancer/Previous Cancer
 Headaches
 Fevers
 Sweats
 Fainting
 Dizziness
 Clumsiness
 Tremors
 Loss of sleep
 Numbness
 Anxiety
 Depression
 Loss of weight

Muscle & Joints
 Arthritis
 Swollen joints
 Diffuse muscle pain
 Stiff joints
 Back pain
 Neck pain
 Shoulder pain
 Elbow pain
 Wrist pain
 Hip pain
 Knee pain
 Ankle/Foot pain

E.E.N.T
 Frequent colds
 Sinus infection
 Asthma
 Failing vision
 Blurred vision
 Double vision
 Ear aches
 Ringing/buzzing in ears
 Deafness
 Slurred speech
 Difficulty swallowing
 Nosebleeds
 Enlarged glands
 Enlarged thyroid

Respiratory
 Chest pain
 Chronic cough
 Difficulty breathing
 Spitting up blood
 Spitting up phlegm

Cardiovascular
 Heart disease
 Stroke
 Bleeding disorder
 High blood pressure
 Pain over heart
 Hardening of arteries
 Varicose veins
 Swelling of ankles
 Poor circulation
 Heart murmur or arrhythmia

Gentourinary
 Trouble urinating
 Blood in urine
 Kidney infection
 Bed wetting
 Prostate trouble
 Frequent urinating

G.U. For Women
 Painful menstruation
 Excessive flow
 Hot flashes
 Irregular cycle
 Cramps or backache
 Discharge
 Swollen breasts
 Lumps in breasts

Have you ever been on birth control pills?
 Yes () No ()

Are you currently taking birth control pills?
 Yes () No ()

of pregnancies: _____
 # of children: _____

Skin
 Rashes/Itching
 Easy bruising
 Dryness
 Boils
 Hives/Allergies

Gastrointestinal
 Diabetes
 Poor appetite
 Indigestion
 Excessive hunger
 Belching or gas
 Nausea
 Vomiting
 Pain over stomach
 Constipation
 Diarrhea
 Hemorrhoids
 Jaundice
 Gall stones
 Intestinal worms
 Ulcers

Do you have a family history of
 () heart disease?
 () diabetes?
 () stroke?
 () cancer?

Do you currently smoke?
 Yes () No ()
 If no, did you smoke in the past?
 Yes () No ()

Do you exercise?
 Yes () No ()
 If yes, how often? _____

Have you had any
 () fractures?
 () surgeries?
 () motor vehicle accidents?
 () hospitalizations?

Do you take any medications or supplements?
 Yes () No ()

Do you have any other health concerns not listed? _____