



Life 'n Balance

WELLNESS CENTRE

Chiropractic Intake Form

How did you hear about Life 'n Balance? _____

Name: _____ Gender: ____ Occupation: _____

Phone Number: _____ text reminders? Secondary Number: _____

Address: _____ Postal Code: _____

Email (Optional): _____ Date of Birth: _____

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

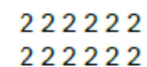
Numbness: 

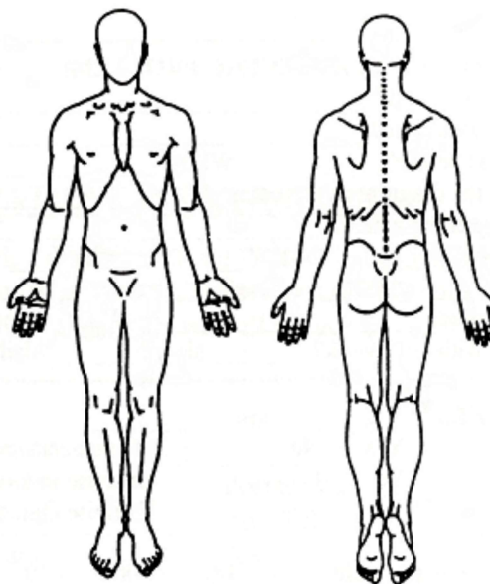
Burning: 

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

4. Do you have a medical doctor? If yes, doctors name: _____
 Do you authorize Life 'n Balance to exchange medical information with your doctor? Yes No

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? _____