

Patient Intake Form

Name: _____ Today's Date: _____

Age: _____ Date Of Birth(d/m/y): _____ Male / Female (circle)

Marital Status: _____ # Of Children & Ages: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone #: Home: _____ Work: _____

Email: _____ Would you like to receive health newsletters? Yes No

Occupation: _____

Please give a brief description of the problem you are currently experiencing and location?

How long have you had this condition? _____

Is it getting worse? Yes No

Does it affect (please check appropriate boxes): work, sleep, other _____

What may have been the cause? _____

Have you seen any other health care providers for this problem? Yes No _____

List all medications you are currently taking including any vitamins and supplements:

Stirke Chiropractic

1Mintleaf Gate, Unit 10, Markham, ON, L3P 5X4
(905) 472-5644 www.drstirke.com

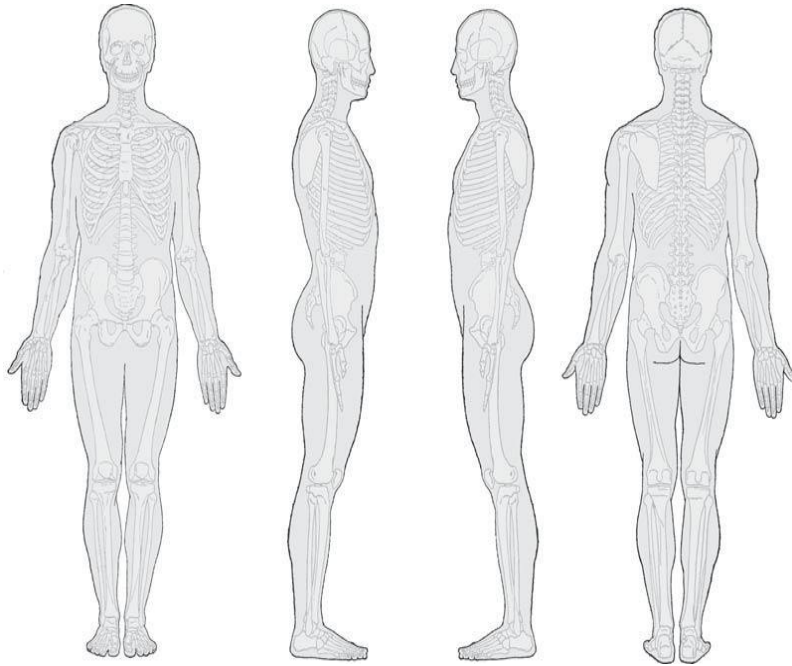
Please circle level of pain you are/have been experiencing:

No Pain

Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Please mark areas of problem/pain on the figure below:



Past Health History

Have you ever... (if yes, explain & list date)

been hospitalized? Yes No _____

had any surgery? Yes No _____

broken any bones? Yes No _____

had any sprains/strains? Yes No _____

been involved in any car accidents? Yes No _____

used orthotics? Yes No _____

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Have you ever suffered from any of the following conditions: (circle)

Diabetes	High Blood Pressure	Neck Pain
Heart Disease	High Cholesterol	Low Back Pain
Arthritis	Stroke	Constipation
Asthma	Osteoporosis	Fatigue
Dizziness	Thyroid Disease	Digestive Problems
Cancer	Multiple Sclerosis	Sinus Trouble
Headache	Allergies	Glaucoma
Anemia	Depression	Epilepsy

Please list any family members/blood relatives with any of the above conditions:

Do you have any other health issues or concerns that our staff should be made aware of?

Females: When was the start of your last period? _____ Are you pregnant? Yes No

Patient Signature

The information and statements I have given on this form are accurate and to the best of my recollection. I understand and agree that all services/care rendered to me are my personal responsibility for timely payment.

Patient's Signature _____ Date: _____

Parent/Guardian's Signature _____ Date: _____