Central Chiropractic & Wellness

Dr. Alden H. Abraham

NEW PATIENT INTAKE & HISTORY FORM

Please fill out this confidential form and bring it to your first office visit

Patient Information

Date: (m.d.y.)

Name:_____E-mail_____

Address:_____Postal Code_____

Phones: Home _____Cell_ _____ _____Work_____

Birth date: (m.d.y)_____Age _____ Marital Status____ Name (Spouse/Partner)_____

Number of children_____Occupation_____Employer_____

Primary M.D._____MD's phone _____MD's City_____

Who may we thank for referring you to our office? _____

How would you like to be reminded of appoint.? (Circle One) E-mail Phone Text (if text, cell company-)

Insurance Information

BC Medical # Premium Assistance? ☐ Yes ☐ No

Extended Health ☐ Yes ☐ No Company:

ICBC Claim# Date MVA: Adjuster 's Name:

Adjuster's Phone: Adjuster's E-mail:

WSBC Claim # Date of Work Injury: Employer

DVA Coverage ☐ Yes ☐ No RCMP Coverage ☐ Yes ☐ No K#

Current Complaints

Why are you seeking care today? _____

_____

Date of injury or when symptom(s) appeared_____ ICBC? WORK? SPORTS? OTHER?_____

Other doctors/therapists seen for this condition_____

What tests and x-ray – CT- MRI imaging have been done for this complaint? _____

_____

Describe your pain and symptoms. How does this affect your life? Rate your pain 0-10 (0=no pain,10=severe pain)

History Name: Date:

What makes the problem better? _____

What makes the problem worse? _____

Is the pain increasing, decreasing, constant? (circle) Does the pain wake you up at night? ☐ Yes ☐ No

Have you had this problem before? ☐ Yes ☐ No Do you have fever, chills, or nausea? ☐ Yes ☐ No

Other associated symptoms: (e.g. numbness ,tingling, achy limb(s), headache, visual, limited motion, locking/catching swelling, redness, fatigue)

Date of last medical examination: Name of MD:

Other health care within 12 months:

List medications taken for this or other conditions:

Vitamins, supplements, herbs?

Previous chiropractor(s):

What are your usual work, exercise, and activity habits? How often? How much? What do you enjoy doing?

Surgeries:

Fractures:

Past auto accidents injuries:

Strains/Sprains:

Concussion(s):

Hospitalization:

Family Health History (parents and siblings especially):

Other lifestyle factors needing attn: (circle) alcohol, smoking, drugs, sugary drinks &food, water intake, salt intake, sleep

Do you wear orthotics? Age of your orthotics? Do you have foot /ankle/knee pain?

Allergies: Latex? Adhesive tape?

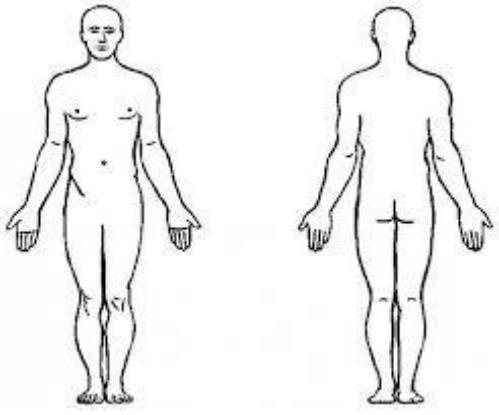
Are you pregnant? How many weeks? Due Date:

Indicate Present (+) Past (*)

Disc Herniation	Sciatica
High Blood Press.	Stroke
Heart Disease	Recent Weight Loss
Cancer	Diabetes
Asthma	Arthritis
Dizziness	Double Vision
Prostate	Urinary Infect.
Kidney Stones	Gall Stones
Ulcers	GI issues
Migraines	Headaches
Blood Clots	Depression
Other	**For Discussion with Dr. Abraham**

N= numb
T= tingling
S=Sharp Pain
D=Dull Pain
B=Burning
P=Pins & Needles
O=Other symptoms

Pain Diagram (please draw your pain and symptoms)



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