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| C:\Users\Dr. Eldon Abraham\Pictures\Website Logo.png |  **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  |

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| **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- ) |

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| **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#  |

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| **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 NoHave you had this problem before? Yes No Do you have fever, chills, or nausea? Yes NoOther 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): |
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| 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 (\*) |  | **Pain Diagram** (please draw your pain and symptoms) |
| Disc Herniation SciaticaHigh Blood Press. StrokeHeart Disease Recent Weight LossCancer Diabetes Asthma ArthritisDizziness Double VisionProstate Urinary Infect.Kidney Stones Gall StonesUlcers GI issuesMigraines HeadachesBlood Clots DepressionOther **For Discussion with Dr. Abraham** | N= numbT= tinglingS=Sharp  PainD=Dull PainB=BurningP=Pins &  NeedlesO=Other  symptoms | C:\Users\Dr. Eldon Abraham\Pictures\download (4).jpg |

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