Airdrie
Family Wellness

Dr. Rebecca Marcucci BSc.,BSC.,DC

PATIENT INTAKE FORM

Last Name: _____ First Name:_____

Address:_____City_____Email:_____

Postal Code:_____ Home Phone:_____ Work Phone:_____

Age: _____ Birth date (dd/mm/yr):_____ Sex: M / F Height _____Weight_____ Cell:_____

Occupation:_____ Alberta Health Care #:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment?_____

When did your condition begin?_____

Have you ever had similar problems? □ Yes □ No

Have you had X-rays, MRI or other tests for this condition? What tests and when?
_____

How did you hear about our clinic? _____

Is this condition related to: Work? □ Yes □ No

Has your employer been notified? □ Yes □ No

Motor vehicle accident? □ Yes □ No Date of injury: _____

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

Can you perform your daily work activities? □ All activities □ Only some □ Not at all

Describe your stress level: □ None □ mild □ Moderate □ High

Do you exercise? □ Daily □ Occasionally □ Not at all

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____
_____

Have you had previous chiropractic care? □ Yes □ No Doctor: Date:_____

Family doctor name:_____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)
_____

Date: _____ Patient Signature: _____

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HEALTH HISTORY

Name:_____

Family History: Please indicate if there is a history of the following in your family.

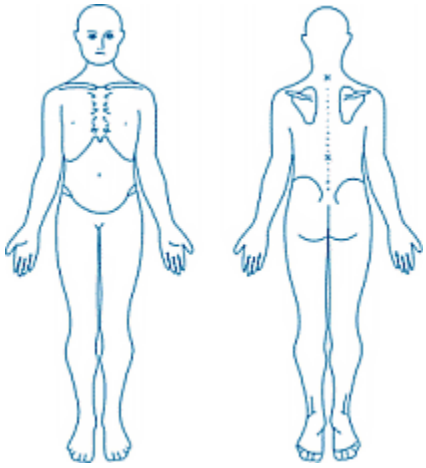
Cancer High Blood Pressure Stroke DiabetesArthritis Other

Medical History:
Please **circle** any conditions that are **presently** causing you a problem and **underline** those that have caused you problems in the **past.**

Cancer High Blood Pressure Stroke Diabetes Arthritis

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hand or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EENT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Are you pregnant? Y/N Date of last cycle _____

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number

| 0 1 2 3 4 5 6 7 8 9 10 |

No Pain Extreme Pain

INFORMED CONSENT TO CHIROPRACTIC CARE (please read carefully)

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or maybe caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature (or Legal Guardian/sign and print)) Date

Witness (sign and print) _____