Patient Intake Form

Full Name: _____

Address: _____

City: _____ Postal Code: _____ Occupation: _____

Email: _____

Date of Birth: (d/m/y)_____/_____/_____ Age:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

What health concern has brought you to our office? _____

Would you describe your symptoms as: (please circle) PAIN DISCOMFORT TENSION STRESS

How would you rank your symptoms on a 0-10 scale? ___/10 (10 is high, 0 is low)

How long has this been affecting you? _____

Which other forms of treatment have you tried? _____

On a scale of 1-10, what is your commitment to getting rid of this problem? _____

How did you hear about our clinic?_____

Name of Medical Doctor: _____

Are you currently taking any medication? (please circle) Yes No

Please List: _____

Have you seen a Chiropractor in the past? (please circle) Yes No

Date of last visit: _____ Chiropractor's Name: _____

Is this an ICBC claim? No____ Yes____ Claim #_____ Date of Accident _____

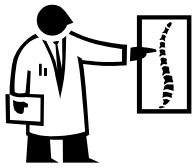
Name of Adjuster: _____Contact Number: _____

We are excited to announce we are able to offer Direct Billing to selected insurance companies

If you have extended health benefits and are interested in direct billing please provide your:

Extended Health Care Provider: _____ **Policy No:** _____ **ID:** _____

We offer this service at no extra charge. Please be aware we are not able to guarantee direct billing due to specifications of with individual benefit plans or problems with submission portal.



HYCROFT CHIROPRACTIC & MASSAGE

Suite 114-3195 Granville St. Vancouver V6H 3K2

STRESS SURVEY: Please circle which forms of stress are currently affect you.

- o Physical
- o Chemical
- o Emotional
- o Postural
- o Occupational
- o Relationship
- o Financial
- o Other_____

HABITS OF DAILY LIVING Please circle that which applies best to you:

Physical Activity Level	Not so Good	Good	Great
• How many times a week do you exercise? _____			
• What form of exercise? _____			
Nutritional Intake	Not so Good	Good	Great
Posture	Not so Good	Good	Great
Smoking Habits	None	Some	Lots
• If yes, for how long? _____ #/day?_____			
Intake of Caffeine	None	Some	Lots
Intake of Alcohol	None	Some	Lots
History of accidents/falls/injuries	None	Some	Lots

1._____

2._____

Systems Review - Please check the following that apply to you:

o	AIDS / HIV	o	Cholesterol	o	Liver Dysfunction
o	Allergies	o	Diabetes	o	Lung Disease
o	Anemia	o	Eating Disorders	o	Menopause
o	Arthritis	o	Epilepsy	o	Osteoporosis
o	Bladder Dysfunction	o	Heart Disease	o	Recurrent Colds / Flues
o	Bleeding Disorders	o	Headaches / Migraines	o	Stroke
o	Blood Pressure (High)	o	Hearing Dysfunction	o	Skin Ailments
o	Cancer	o	Heartburn / Indigestion	o	Visual Disturbances

EXCEEDING YOUR EXPECTATIONS

What are your expectations from chiropractic care? _____

What are your long-term health goals? _____

Thank you for choosing Hycroft Chiropractic & Massage!