Skryzlo Family Chiropractic

Patient Intake Form

Personal Information

Full Name: _____

Date of Birth (DD/MM/YYYY): _____

Age: _____

Address: _____

City, Province: _____ Postal Code: _____

Occupation: _____

Contact Information

Phone Number: _____

Email Address: _____

Emergency Contact Name/Number:_____

Medical Information

Current Health Conditions (Check all that apply)

Musculoskeletal: ☐Arthritis ☐ Osteoporosis ☐ Scoliosis ☐Joint Swelling ☐ Chronic Pain

Neurological: ☐Frequent Headaches ☐ Dizziness ☐ Numbness/Tingling ☐ Sciatica

Cardiovascular: ☐High Blood Pressure ☐ Poor Circulation ☐Pacemaker ☐ Stroke

Other: ☐Diabetes ☐ Autoimmune Disease ☐ Cancer

Previous Surgeries or Hospitalizations

Have you ever had surgery? □Yes □ No

If yes, please list all surgeries/hospitalizations, including the approximate date and reason:

_____

_____

Current Medications

Are you currently taking any prescription medications? □Yes □ No

Are you currently taking any over-the-counter medications, vitamins, supplements, or herbal products? □Yes □ No

If yes, please list all medications and supplements: _____

_____

_____

Allergies

□No known allergies

□Allergic to: _____

Injury/Condition Information

What is the reason for your visit?_____

List your symptoms:_____

When did your symptoms begin?_____

How did the injury or problem occur?

□Motor Vehicle Accident □ Work-Related Injury □ Sports Injury □ Slip/Fall □ Gradual Onset □ Unknown

□Other: _____

How would you describe the pain? (Check all that apply)

☐Dull/Aching ☐ Sharp/Stabbing ☐ Burning ☐ Throbbing ☐ Numb/Tingling ☐ Stiffness

☐Other:

_____

Does the pain radiate anywhere? ☐No ☐ Yes, to:_____

Pain Level (10 being the worst pain possible):

0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse/better?_____

Have you received any treatment for this injury? □Yes □ No

If yes, please describe:_____

Have you had any diagnostic imaging? □ X-ray □ MRI □ CT Scan □ Ultrasound

Lifestyle & Health Habits

Do you currently smoke, use tobacco products, or vape? □Yes □ No

Do you drink alcohol? □Yes □ No

If yes, how often? _____

Occupational Posture: ☐ Primarily Sitting ☐ Heavy Lifting ☐ Standing ☐ Repetitive Motion

Physical Activity Level: ☐ Sedentary ☐ Light Exercise ☐ Moderate ☐ Heavy Training

Sleep Position: ☐ Side ☐ Back ☐ Stomach

Stress Level: ☐ Low ☐ Moderate ☐ High

Consent for Evaluation

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractic staff to perform an evaluation for the purpose of diagnosis and treatment planning.

Patient/Guardian Signature:_____

Date: _____