Dr. Shawna Skryzlo, BSc., D.C.

Patient Intake Form

Personal Information

Full Name: _____

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

Age: _____

Gender: _____

Address: _____

City, Province: _____ Postal Code: _____

Occupation: _____

Contact Information

Phone Number: _____

Email Address: _____

Emergency Contact Name/Number:_____

Chiropractic History

Have you ever seen a chiropractor before? ☐ Yes ☐ No

If yes:

Name of chiropractor/clinic: _____

Date of most recent visit: _____
Reason for treatment: _____
Did you experience improvement with chiropractic care?
☐ Yes ☐ No ☐ Somewhat

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:

Surgery/Hospitalization	Date	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: _____

Do you have any medical implants/devices? ☐ Yes ☐ No

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

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?_____
What makes the pain 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 or use tobacco products? ☐ 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

Average Daily Water Intake: _____

Stress Level: ▫ Low ▫ Moderate ▫ High

Female Health (Optional)

Are you currently pregnant?

☐ Yes
☐ No
☐ Prefer not to answer

If yes, how many weeks pregnant are you? _____

Do you have any gynecological or reproductive health conditions that may be relevant to your care?

☐ Yes

☐ No

☐ Prefer not to answer

Is there any additional information about your health, lifestyle, or medical history that you would like your chiropractor to know?

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:

_____