16945 Leslie St
Unit 17
Newmarket, ON
L3Y 9A2

Tel: 905.898.8098
Fax: 905.898.8099

FosterFamilyChiropractic
& ASSOCIATES

CHIROPRACTIC ADULT INTAKE FORM

When complete, please bring this form with you to your first appointment.

Patient Information

First Name _____ Last Name _____

Street Address _____ Apartment _____

Town/City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____

Cell _____ E-Mail _____

Birth Date _____ Age _____ Sex _____

Marital Status _____

Occupation _____ Employer _____

Spouse's Name _____ Occupation _____

No. of Children _____

Height _____ ☐ cm ☐ in Weight _____ ☐ kg ☐ lbs

How did you hear about our office? _____

Were you referred to this office? ☐ Yes ☐ No

If yes, by whom? _____

Health History

Purpose of contacting us? _____

How long have you been experiencing this? _____

Is it getting better or worse over time? ☐ Better ☐ Worse

Other health care professionals consulted for this problem _____

_____

Have you been hospitalized for this problem? ☐ Yes ☐ No How many days? _____

Are you content with your present level of health? ☐ Yes ☐ No

If not, what aspect would you change? _____

Is your complaint the result of a work injury or car accident? ☐ Yes ☐ No

If yes, please explain _____

Other health problems? _____

Name of your medical doctor _____ Date of last visit _____

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Select any of the following that you are experiencing now or have experienced in the recent past:

☐ Anemia	☐ Allergies	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Anxiety / Panic	☐ Dizziness	☐ Diabetes	☐ Tension	☐ Insomnia
☐ Headache	☐ Sinus Trouble	☐ Heart Trouble	☐ Vision Problems	☐ Numbness / Tingling
☐ Backache	☐ Growing Pains	☐ Neck Aches	☐ Depression	☐ Colic
☐ Epilepsy	☐ Hepatitis	☐ Nausea / Vomit	☐ Rheumatism	☐ Nervousness
☐ Digestive Problems	☐ Loss of Memory	☐ Muscular Dystrophy	☐ Multiple Sclerosis	☐ Leg Pain
☐ Shortness of Breath	☐ Extreme Fatigue	☐ Chest Pain	☐ High Blood Pressure	☐ Feet / Hands Cold
☐ Ear Infections	☐ Ears Buzzing / Ringing	☐ Limited Neck Motion	☐ Limited Midback Motion	☐ Limited Low Back Motion
☐ Head & Shoulders Tired and Heavy		☐ Attention Problems - ADD/ADHD		

Please describe:

Past Injuries _____

Prior Surgery _____

Prior Hospitalizations _____

Prior Motor Vehicle Accidents _____

Medication Used (in childhood or adulthood) _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list _____

Are you presently taking any herbal or vitamin supplementation? ☐ Yes ☐ No

If yes, please list _____

How often do you exercise? _____

What type of exercise? _____

Do you smoke? ☐ Yes ☐ No

Previous Care

Have you ever had chiropractic care in the past? ☐ Yes ☐ No

Reason for care _____

Doctor seen _____

Additional Comments

_____

_____

_____

_____

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CONSENT for examination: Please Reads Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I understand that I can at any time discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name:_____ **Date:** _____

Signature:_____ **Witness:**_____

Doctor of Chiropractic:

Please complete this form prior to arriving at our office. If you have any questions, please do not hesitate to contact our office at 905-898-8098, or wait until your appointment time. We are excited that you have chosen Dr. Laura Foster & Dr. Danielle Warner for your chiropractic care. It is our pleasure to welcome you and your family to the most natural form of health care, chiropractic.

Instructions for First Appointment

Our office utilizes the most advanced form of non-invasive diagnostic procedures available. Please refrain from intense exercise 6 hours prior to your appointment time, as well as avoiding heat/ice, caffeine and over-the-counter (non-prescription) medications. These may interfere with the quality of your diagnostic results. Please call if you have any questions.

We look forward to seeing you.