Profile Information — Step 1 of 4

You are completing the following intake forms: Chiropractic Intake Form

You are filling out an intake form for

Patient Name

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

Only staff members can edit this information on an intake form.

First Name – *Required*

Last Name – *Required*

Email – *Required*

Preferred Name (if different)

Please provide at least one phone number. Your mobile number can be used to look up your Account.

Home Phone – *Required*

CA

Mobile Phone – *Required*

CA

A mobile phone is required if you would like to receive SMS appointment reminders.

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

Province – *Required*

Select a Province...

Country – *Required*

Canada

Postal Code – *Required*

Date of Birth – *Required*

Month

Select a month...

Day

XX

Year

XXXX

Gender

Sex

Select an option...

Personal Health Number

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of Referring Professional

Referring Professional Phone (if known)

Referring Professional Email (if known)

How Did You Hear About Us?

Select an option...

Who Were You Referred To?

Select an option...

Insurance Information — Step 2 of 4

You are completing the following intake forms: Chiropractic Intake Form

Your insurance policy

Please note we can only bill your primary insurance. If you do not see your insurance company listed we do not bill them directly.

Insurer

Select an insurer

Questionnaires — Step 3 of 4

You are completing the following intake forms: Chiropractic Intake Form

Chiropractic Intake Form

Please Note*

If you are uncomfortable submitting any of the following information, please indicate you wish to discuss verbally during your appointment.

Please tell us about your primary complaint or if you are here for preventative/wellness care.*

Rate on a scale of 0 to 10 your pain / discomfort level today

0 - Being no pain or discomfort | 1 | 2 Mild discomfort | 3 | 4 | 5 Moderate pain / discomfort | 6 | 7 | 8 Moderate to severe pain / discomfort | 9 | 10 Most pain / discomfort you have ever felt

Secondary or other areas of complaint (please provide a brief description of your other areas of complaint)(if applicable)

Were you injured at work or in a car accident? (If so, please describe the incident)

Please list any other treatments you have had for this treatment and results achieved (ie. surgery, acupuncture, massage therapy, chiropractic care, osteopathic care, physiotherapy) Please include dates.

Health History Questionnaire (please check all current or previous conditions as they may apply)

General Symptoms*

- [ ] History of loss of consciousness
- [ ] History of Headaches
- [ ] History of Migraines
- [ ] Fever

- [ ] Excess Sweating
- [ ] Night Sweats
- [ ] Night Pain
- [ ] Generalized Pain
- [ ] Nervousness
- [ ] Convulsions
- [ ] Loss of Sleep
- [ ] Allergies
- [ ] Leg pain
- [ ] Arm pain
- [ ] None

Neurological Symptoms*

- [ ] Dizziness
- [ ] Fainting
- [ ] Problem Speaking
- [ ] Blurred Vision
- [ ] Nausea
- [ ] Numbness or tingling
- [ ] None

Eyes / Ears / Nose / Throat Symptoms*

- [ ] Failing Vision
- [ ] Vision Problems
- [ ] Eye Pain
- [ ] Ringing / Buzzing in ears
- [ ] Hearing Loss
- [ ] Other Hearing problems not otherwise listed
- [ ] None

Respiratory Symptoms*

- [ ] Asthma
- [ ] Chronic Cough
- [ ] Difficulty Breathing
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Emphysema
- [ ] None

Cardiovascular Symptoms*

- [ ] Bleeding Disorder
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Previous incident of Stroke
- [ ] Cerebral Vascular Aneurism
- [ ] Hardening of Arteries
- [ ] Swelling of Ankles
- [ ] Poor Circulation
- [ ] Angina
- [ ] Chronic Congestive Heart Failure
- [ ] Previous Heart Attacks
- [ ] Phlebitis / Varicose veins
- [ ] Pacemaker or similar device
- [ ] Other Heart / Blood Disease not discussed
- [ ] None

Gastrointestinal Symptoms*

- [ ] Irregular / Absent bowel movement
- [ ] Ulcer
- [ ] Diabetes
- [ ] Indigestion
- [ ] None

Genitourinary Symptoms*

- [ ] Trouble Urinating
- [ ] Kidney Infection
- [ ] Prostate Trouble
- [ ] None

Optional - may help us understand your pain if applicable

- [ ] Irregular / Absent Cycle
- [ ] Cramping / Backache
- [ ] Currently on birth control
- [ ] History of being on birth control
- [ ] Currently pregnant
- [ ] History of childbirth
- [ ] History of C-section

Have you ever had any fractures ? (If Yes, please provide details and dates)

- [ ] YES

- [ ] NO

Have you ever been diagnosed with Cancer ? (If Yes, please provide details and dates)*

- [ ] YES

- [ ] NO

Please list your current Medication, Herbs, Supplements.

Do you suffer from any allergies related to seasons, herbs, foods, animals, drugs, or others ? (If yes, please provide any pertinent detail)

Family Medical History (Please check all applicable conditions)*

- [ ] Headaches or Migraines
- [ ] High or Low blood pressure
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Fainting or Dizziness
- [ ] Stroke
- [ ] Circulatory Problems
- [ ] Cancer
- [ ] Neurological disorders
- [ ] kidney disease
- [ ] Chron's Disease
- [ ] Pelvic Inflammatory disease
- [ ] Asthma
- [ ] Respiratory disorders
- [ ] Rheumatoid arthritis
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Fibromyalgia
- [ ] Epilepsy
- [ ] Skin Conditions
- [ ] Multiple Sclerosis
- [ ] None

What are your main interests and hobbies?

Occupation

Tell us about your typical day

What is your exercise/activity level? Tell us about what you do for self care?

What are your goals with Chiropractic care?

Please add any additional information that you feel is pertinent

Consents — Step 4 of 4

You are completing the following intake forms: Chiropractic Intake Form

Communication

Appointment Notifications and Reminders

Email

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [ ] **I would like email notifications of new, cancelled, and rescheduled appointments**

- [ ] **Email 2 days before appointment**

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- [ ] **Text Message (SMS) 24 hours before appointment**
- [ ] **Text Message (SMS) 2 hours before appointment**

News and Special Promotions

- [ ] **Yes, I would like to receive news and special promotions by email**

Chiropractic Intake Form — Consents

Accuracy of Information *– Required*

- [ ] **I certify that the above medical information is correct to my knowledge.**

Privacy and Sharing of Information *– Required*

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] **I agree**

Cancellation Policy *– Required*

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 48 hours notice for any cancellations or changes to your appointment. Patients who provide less than 48 hours notice, or miss their appointment, will be charged a cancellation fee.

- [ ] **I am aware of the Cancellation Policy.**

Consent to Share File *– Required*

I authorize my file to be shared with other practitioners in the Partners in Health office.

- ( ) **I agree**
- ( ) **I disagree**

Signature *– Required*

Draw **Type**

Scroll to top

Submit Intake Form

(https://jane.app)

Terms of Use (https://jane.app/terms) Privacy Policy (https://jane.app/privacy)