evoke
WELLNESS CENTRE

Chiropractic
confidential patient intake form

Name: _____ Date: _____

Date of Birth(mmm/dd/yyyy): _____ Male O Female O Other O

Address: _____ City: _____ Postal Code: _____

Home Phone _____
Cell Phone _____
Email _____

Set up your appointment reminders
Text reminders Y / N
*Cell Provider*_____
Email reminders Y / N

Occupation: _____

Work phone: _____ Employer: _____

Spouse: _____ Children:_____

Care Card # *(Premium Assistance or ICBC)*: _____ Height: _____

How did you hear about our office? _____ Weight: _____

If you were referred to our office who can we thank? _____

Emergency Contact Name**:** _____ Phone: _____

Previous Chiropractic Name: _____ Date of last visit: _____

Family Doctor Name**:** _____ Date of last visit: _____

Other Health Care Professionals:
Name: _____ Profession: _____

Name: _____ Profession: _____

ICBC or WCB

Are your injuries related to an **ICBC** case? Yes O No O **WCB**? Yes O No O

Date of accident (mmm/dd/yyyy): _____ Claim #: _____

Adjustor's name: _____ Phone: _____

Please Note: Your appointment time has been reserved for you. We ask that you provide us with at least **24 hours notice** of cancellation. If you fail to do so the full appointment fee will apply. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.
I have read and understood the fee schedule and cancellation policy. I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

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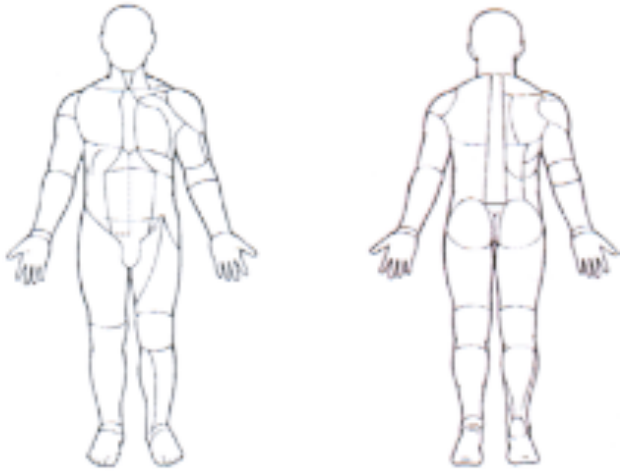
Name: _____

Please Check One Of The Following:

- O I have a specific health complaint that I am seeking relief for
- O I am here for a specific health complaint and am interested in strategies to help prevent its return
- O I have no specific complaints and am interested in preventative wellness care

Primary Complaint:
Please mark areas of concern:



Please describe your current condition & symptoms:

_____

_____

_____

_____

_____

_____

_____

_____

Have you experienced this complaint previously? Yes O No O If yes, when? _____

Is this condition preventing you from doing anything? Yes O No O If yes, what? _____

Please list any medications being taken: _____

Please list any previous surgeries, accidents or trauma (include dates): _____

_____

Have you been hospitalized for any reason? Yes O No O Please list: _____

Please list any current or past medical conditions: _____

Please list any serious allergies: _____

Do you have a family history of: Cancer O Diabetes O Heart Disease O Stroke O
Arthritis O High Blood Pressure O Other O _____

Have you had any recent unexplained weight loss? Yes O No O

Have you had any unexplained fever or night sweats? Yes O No O

Hours of physical activity per week? _____

Do you smoke? Yes O No O How many cigarettes per day? 1-5 O 6-12 O 13-20 O 20+ O

Do you drink alcohol? Yes O No O How many drinks per week? 1-7 O 8-14 O 14+ O

Please list any previous X-Ray, CT or MRI imaging taken: _____