3133 Birds Hill Rd
East St. Paul, MB
R2E 1G9
(204) 777-2225

EAST ST. PAUL
FAMILY CHIROPRACTIC

Dr. Kody Fawcett D.C.

New Patient Intake Form

Full Name: _____ Date:_____
Address: _____
City: _____ Province: _____ Postal Code_____
E-Mail:_____
Age: _____ Date of Birth: _____
Sex: ( ) Male ( ) Female
Relationship: ( ) Single ( ) Married
Home Phone: _____
Cell Phone: _____

In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

How did you hear about this office? _____

Primary and Secondary Complaints

Is your current condition the result of a ***recent**:* ( ) auto accident ( ) work related injury

Symptom #1: _____

When did it start? _____

How often do you experience this problem? _____

Intensity: _____/10

How would you describe the symptoms? ( ) Burning ( ) Sharp ( ) Stabbing ( ) Dull ( ) Achy

Does it radiate anywhere (ex. down legs/arms) _____

Is this problem getting: ( ) worse ( ) better ( ) staying the same

What makes it worse? _____

What makes it better? _____

Symptom #2: _____

When did it start? _____

How often do you experience this problem? _____

Intensity: _____/10

How would you describe the symptoms? ( ) Burning ( ) Sharp ( ) Stabbing ( ) Dull ( ) Ache

Does it radiate anywhere (ex. down legs/arms) _____

Is this problem getting: ( ) worse ( ) better ( ) staying the same

What makes it worse? _____

What makes it better? _____

Your Health Profile

Have seen a chiropractor before? ( ) Yes ( ) No
If yes, which office? _____
Approximate date of last visit: _____

Lifestyle / Social History

Job Description: _____
Recreational Activities: _____
Do you smoke? Y N If yes, how much? _____
Do you drink alcohol? Y N If yes, how much? _____
How regularly do you exercise? ( ) daily ( ) ___x/week ( ) occasionally ( ) never
What kind of exercise do you do? ( ) Weight Training ( ) Walking ( ) Running
Other: _____
How many hours of sleep do you get on average? _____
On a scale of 1-10 please rate your stress level (1=none and 10=extreme):
Occupational: ____ Personal: ____

Surgeries:

Approx. Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Medications:	**Reason for taking:**
_____	_____
_____	_____
_____	_____

Nutritional Supplements: _____
_____

Disclosure of Personal Health Information

____(initials) We are concerned with protecting the privacy of your personal health information. The law requires us to notify you about this disclosure. It may be necessary for us to disclose your health information to another health care provider if it is necessary for them for the diagnosis, assessment, or treatment of your health condition. I give East St. Paul Family Chiropractic and its representatives permission to communicate with me via the contact information provided.

____(initials) I consent to a professional chiropractic examination and to any radiographic examination that the doctor deems necessary. Females: I confirm to the best of my knowledge that I am not pregnant, which would exclude me from any radiographic examination.

Patient or Guardian Signature: _____ Date: _____