DYNAMIC BALANCE
Physiotherapy & Sports Injuries Centre

11 Gibb Street
Oshawa, ON L1H 2J9
T: 905-404-3434
F: 1-866-623-8188
E: info@dynamicbalancephysio.com

CHIROPRACTIC INTAKE FORM

Welcome to DYNAMIC BALANCE PHYSIOTHERAPY AND SPORTS INJURIES CENTRE. Please fill in the information below to the best of your ability. If you have any questions, feel free to ask the administration staff, who will be happy to assist you.

PATIENT INFORMATION

FIRST NAME:		**LAST NAME:**
DATE OF BIRTH:		**GENDER:** ☐ MALE ☐ FEMALE ☐ OTHER
STREET ADDRESS:		
CITY:	**PROVINCE:**	**POSTAL CODE:**
HOME PHONE #:		**CELL PHONE #:**
WORK PHONE #:		**E-MAIL:**
BEST CONTACT METHOD: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ E-MAIL		
OCCUPATION(S):		
HAVE YOU HAD CHIROPRACTIC CARE BEFORE?: ☐ YES ☐ NO		
APPROXIMATE DATE OF LAST CHIROPRACTIC VISIT:		
HOW DID YOU HEAR ABOUT US?: ☐ GOOGLE/WEB SEARCH ☐ REFERRAL ☐ OTHER		
REFERRED BY:		

EMERGENCY CONTACT

EMERGENCY CONTACT NAME:
EMERGENCY CONTACT PHONE #:

FAMILY DOCTOR

FAMILY DOCTOR NAME:
FAMILY DOCTOR PHONE #:
HAVE YOU SEEN YOUR PCP REGARDING YOUR PRIMARY COMPLAINT?: ☐ YES ☐ NO

HEALTH INFORMATION

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

☐ DIABETES	☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL	☐ HISTORY OF HEART DISEASE
☐ HISTORY OF CANCER	☐ ARTHRITIS
☐ OSTEOPOROSIS	☐ UNRELENTING PAIN
☐ NIGHT PAIN	☐ INCONTINENCE
☐ UNEXPLAINED WEIGHT LOSS	☐ RHEUMATOID ARTHRITIS
☐ PACEMAKER	☐ JOINT REPLACEMENT/METAL IMPLANTS
☐ AIDS/HIV, HEPATITIS, OR TB	☐ ALLERGIES
☐ ALLERGIES	☐ RECENT SURGERY

☐ RECENT TRAUMA (EG. BROKEN BONES, DISLOCATIONS, MOTOR VEHICLE ACCIDENTS, ETC.)

PLEASE LIST ANY PAST OR CURRENT MEDICAL CONDITIONS NOT LISTED ABOVE:

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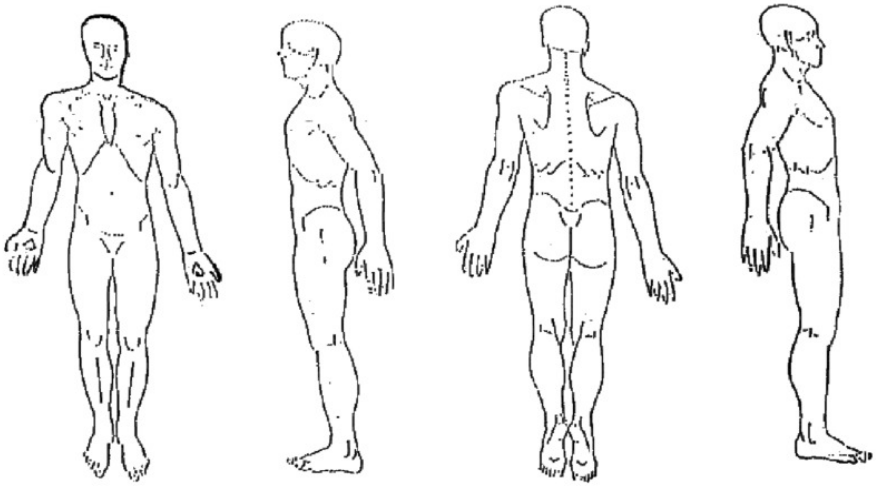
PRIMARY COMPLAINT INFORMATION

MAIN REASON FOR YOUR VISIT TODAY:
WAS YOUR PRIMARY COMPLAINT THE RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO **IF YES, PLEASE COMPLETE THE MOTOR VEHICLE ACCIDENT PACKAGE**
WAS YOUR PRIMARY COMPLAINT THE RESULT OF A WORKPLACE ACCIDENT? ☐ YES ☐ NO **IF YES, PLEASE COMPLETE THE WSIB PACKAGE**

Using the following legend, please indicate on the diagram below where you are currently experiencing pain or other symptoms.

A = Achy	**B = Burning**
N = Numbness	**P = Pins & Needles**
S = Sharp/Stabbing	**O = Other**



CONSENT TO EXAMINATION

I grant Dr. Josh Ibe consent to perform all procedures deemed appropriate to assess area(s) of complaint listed below. All of the information that I give below is recent and true. I understand that all of the information that I have provided below will remain strictly confidential; and all details of my patient file will be limited only to the parties directly responsible for my care. None of the subsequent information below will be able to be released without my written consent and approval.

PATIENT SIGNATURE: _____ DATE: _____