

Intake Form

Date:
Year Month Day

Date of Birth:
Y M D

Name: _____ Preferred Pronouns: _____

Address: _____ Town/City _____ Postal Code _____

Contact Numbers: (C) _____ (W) _____ Email Address: _____

Family Physician: _____ Referring Practitioner: _____

How did you hear about us? Doctor ____ Family/Friends ____ Past Patient ____ Website ____ Social Media ____ Other ____

What is your goal of treatment? _____

Medical History

Please indicate if you have a history of any of the conditions listed below:

1. Seizure Disorder Yes ☐ No ☐

6. Cardiac History Yes ☐ No ☐

2. Arrhythmia Yes ☐ No ☐

7. High Blood Pressure Yes ☐ No ☐

3. Cardiac Rhythm Device Yes ☐ No ☐

8. Circulatory Disorder Yes ☐ No ☐

4. Spinal Stimulator/Cochlear Implant Yes ☐ No ☐

9. Unexplained Weight Loss Yes ☐ No ☐

5. Diabetes Yes ☐ No ☐

10. Recent Fever/Infection Yes ☐ No ☐

Continued ►

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11. Arthritis: Rheumatoid/Osteo/Other Yes ☐ No ☐

19. Relevant Imaging: Xray/MRI/CT/Ultrasound Yes ☐ No ☐

12. Bone Density: Osteopenia/Osteoporosis Yes ☐ No ☐

20. Currently Taking Anticoagulants Yes ☐ No ☐

13. Surgery Yes ☐ No ☐

21. History of Taking Oral Steroids Yes ☐ No ☐

14. Metal or Plastic Implants Yes ☐ No ☐

22. Pregnancy/Gynecological Conditions Yes ☐ No ☐

15. Infectious Diseases Yes ☐ No ☐

23. Other General Health Concerns/Conditions Yes ☐ No ☐

16. Cancer Yes ☐ No ☐

24. Current Medication List:

17. Receiving Other Care for Condition Yes ☐ No ☐

Other:

18. Recent Workplace or Motor Vehicle Injury Yes ☐ No ☐