

Dr. Jabeen Jussa, B.Sc., D.C.  
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

**PATIENT INTAKE FORM**

Today's Date \_\_\_\_\_

NAME \_\_\_\_\_ HOME TEL \_\_\_\_\_

ADDRESS \_\_\_\_\_ WORK TEL \_\_\_\_\_

\_\_\_\_\_ MOBILE TEL \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ CARE CARD # \_\_\_\_\_

OCCUPATION \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_

DATE OF BIRTH (m/d/y) \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

TEL \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_ Have you received Chiropractic care before? Y N

Would you like to join our email Newsletter? \_\_\_\_\_ (write email address)

Are you claiming:

Worker Compensation Board Y N Claim # \_\_\_\_\_ Adjustors Name: \_\_\_\_\_

I.C.B.C Y N Claim # \_\_\_\_\_ Adjustors Name: \_\_\_\_\_

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently Experiencing.

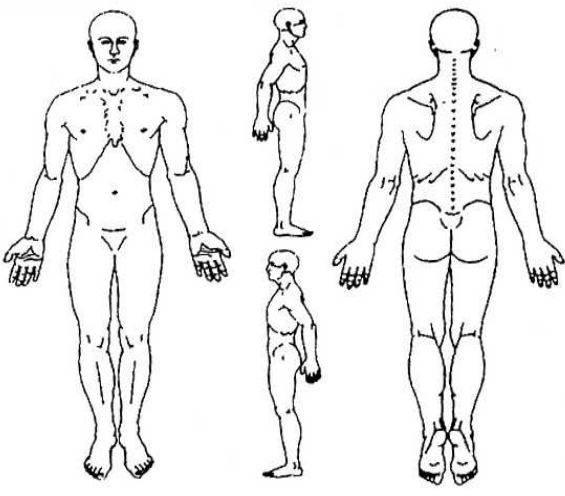
- A** = Ache
- B** = Burning
- N** = Numbness
- O** = Other
- P** = Pins & Needles
- S** = Stabbing

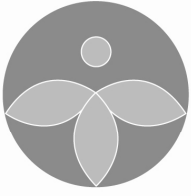
Please provide any further details:

\_\_\_\_\_

Are your symptoms changing?

- ( ) Improving
- ( ) Not Changing
- ( ) Getting Worse





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Please mark with an “X” if you are currently experiencing or have experienced any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> headaches               | <input type="checkbox"/> general fatigue        | <input type="checkbox"/> sciatica             |
| <input type="checkbox"/> neck pain               | <input type="checkbox"/> depression             | <input type="checkbox"/> hay fever            |
| <input type="checkbox"/> jaw pain                | <input type="checkbox"/> slipped disc           | <input type="checkbox"/> migraines            |
| <input type="checkbox"/> pain between shoulders  | <input type="checkbox"/> difficulty swallowing  | <input type="checkbox"/> neck spasms          |
| <input type="checkbox"/> low back pain           | <input type="checkbox"/> anemia                 | <input type="checkbox"/> loss of weight       |
| <input type="checkbox"/> sinusitis               | <input type="checkbox"/> visual problems        | <input type="checkbox"/> night sweats         |
| <input type="checkbox"/> stroke                  | <input type="checkbox"/> ear infections         | <input type="checkbox"/> clicking in neck     |
| <input type="checkbox"/> dizziness               | <input type="checkbox"/> cold hands/feet        | <input type="checkbox"/> liver trouble        |
| <input type="checkbox"/> nausea                  | <input type="checkbox"/> stomach pain           | <input type="checkbox"/> excessive gas        |
| <input type="checkbox"/> loss of vision          | <input type="checkbox"/> heart burn/indigestion | <input type="checkbox"/> gall bladder stones  |
| <input type="checkbox"/> loss of taste/smell     | <input type="checkbox"/> loss of memory         | <input type="checkbox"/> painful urination    |
| <input type="checkbox"/> fainting spells         | <input type="checkbox"/> bladder infections     | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> loss of consciousness   | <input type="checkbox"/> ulcers                 | <input type="checkbox"/> aortic aneurysm      |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> prostate problems      | <input type="checkbox"/> diarrhea             |
| <input type="checkbox"/> arthritis               | <input type="checkbox"/> blood disorders        | <input type="checkbox"/> constipation         |
| <input type="checkbox"/> allergies               | <input type="checkbox"/> diabetes               | <input type="checkbox"/> kidney problems      |
| <input type="checkbox"/> asthma                  | <input type="checkbox"/> cancer                 | <input type="checkbox"/> chest pain           |
| <input type="checkbox"/> shortness of breath     | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> heart attacks        |
| <input type="checkbox"/> pinched nerve           |   |   |

Have you undergone any surgeries? Y N If yes, briefly describe

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Have you ever had any falls, injuries, car accident, traumas, head injuries, accidents? Y N

Describe

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Are you currently taking any medications (prescription or over the counter) Y N

List:

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Are you currently taking any vitamins, minerals or herbal supplements Y N

List:

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