Dr. Ansel Updegrove, B.A., D.C.

PATIENT INTAKE FORM

PERSONAL INFORMATION	
Name:	Today's Date (mm/dd/yyyy):
Date of Birth (mm/dd/yyyy):	Age: Gender: □Female □Male
Street address:	E-mail:
City:	Home Phone:
Province:	Work Phone:
Postal Code:	Cell Phone:
Your Occupation:	Employer:
Spouse/Partner:	Children: □Yes □No
Emergency Contact:	Emergency Contact Number:
Relation to You:	

I hereby give consent to receive phone calls/text messages/e-mails from Dr. Ansel Updegrove.
Authorization will expire upon my request.
This information will not be shared with anyone outside of Dr. Ansel's clinic.
□Yes □No

How did you hear about our clinic: □Doctor □Health Care Professional □Friend □Internet	
Other:	Whom can we thank for the referral?

INSURANCE CLAIMS	
BC Medical Care Card #:	
Extended Coverage: □Yes □No Company: Group # ID #:	
MSP Assisted Medical Coverage: □Yes □No	If unsure, check with staff to see if you qualify
Recent motor vehicle accident: □Yes □No	If yes, see ICBC forms
Work related injury/accident: □Yes □No	If yes, see WorkSafe/WCB forms

PRIOR CHIROPRACTIC CARE	
Name:	City:
X-rays taken: □Yes □No Date:	Results: □Excellent □Good □Fair □Poor

MEDICAL DOCTOR	
Name:	City:
Date of Last Appointment:	
Do you give consent for Dr. Ansel Updegrove to access any reports or images (CT, MRI, X-ray) from VIHA and other facilities? □Yes □No	

I fully understand that I will pay Dr. Ansel Updegrove for services rendered on the day they are received.

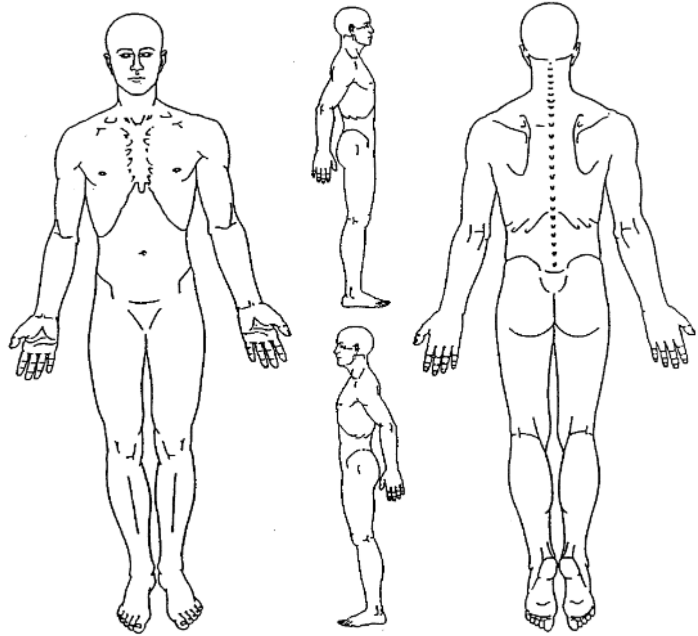
_______________________________ _______________________

(Signature) (Date)

HEALTH HISTORY	
Name:	Today's Date (mm/dd/yyyy):

Show area(s) of pain or unusual feeling by marking these area(s) on the figures below using the appropriate symbols. Include all affected areas and mark their radiating area(s).

Stabbing	///////// /////////
Burning	XXXXXX XXXXXX
Aching	* * * * * * * * * * * * * *
Numbness	••••••••• •••••••••
Pins & Needles	OOOOO OOOOO



Reasons for consulting this clinic:
Expectations:
Falls & Accidents (list):
Surgeries & Operations (list):
Current Medications/Drugs (list):

Have you ever had any of the following conditions or problems with:

- □ Aneurysm
- □ Strokes
- □ Hepatitis
- □ Asthma
- □ Osteoporosis
- □ Diabetes
- □ Epilepsy
- □ Fatigue
- □ Pneumonia
- □ Psoriasis
- □ Arthritis
- □ Cancer
- □ Polio
- □ Pleurisy
- □ V.D.
- □ HIV
- □ Allergies
- □ Sinus conditions
- □ Sleeping difficulty
- □ Heart/Arteries
- □ Brain/Nervous system
- □ Digestive system
- □ Eyes/Ears/Nose/Throat
- □ Urinary system
- □ Immune system
- □ Reproductive system
- □ Respiratory conditions
- □ Bones/Joints
- □ Skin
- □ Motor Control