Dr. Michelle Fabbro, DC
Jade Wellness
677 Queen St E, Sault Ste. Marie, ON P6A 2A6
(705) 257-7707

New Patient Intake Form

Date: ___________________

Patient Information

Name:_____________________________________ Birthdate:____________________ Age:________________

Address: ___________________________________ City: ________________________Postal Code:____________

Home Phone: ____________________________________ Cell Phone:__________________________________

Email:____

Occupation:____________________________________ Work Phone:__________________________________

Referred by:____________________________________ Family Physician:______________________________

Emergency Contact:____________________________ Relationship:________________ Phone #:_____________

Health Information

Reason for Attending Office:____

Location of Pain? ____

How long have you had this condition? ____

Have you had this (or similar) conditions in the past? ____

Was there a specific incident that brought on the pain? ☐ Yes ☐ No

Was the onset of pain: ☐ Sudden ☐ Gradual

Pain aggravated by? ____

Pain relieved by? ____

Is there a time of day where the pain is worse? ☐ Morning ☐ Evening ☐ Constant

On a scale of 0 (no pain)-10 how would you rate your current pain level? ___________________________

Is the condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes and Goes ☐ Improving

Is this interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: ____

Have you had previous chiropractic care? ☐ Yes ☐ No

Other treatments tried for this condition:____

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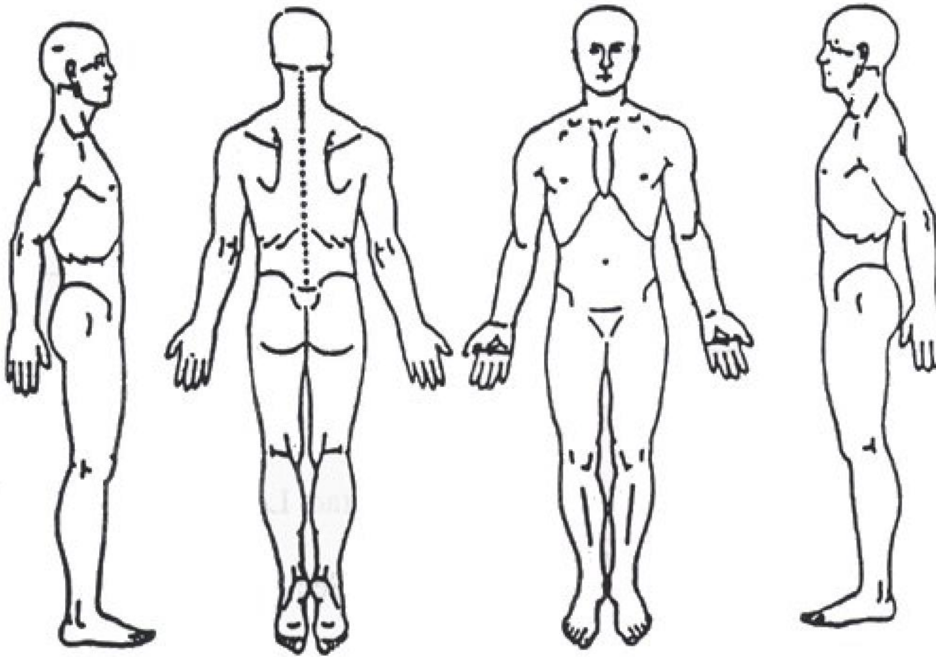
On the following diagram indicate where you are feeling pain:

Numbness: N   Aching: = =   Stabbing: XX Burning: B   Stiffness: S   Pins and Needles: ::: Dull: D   Cramps: C



Past Health History

Please check if you presently have OR have had any of the following conditions in the past:

☐ Blurring Vision	☐ Bronchitis	☐ Ringing in the ears	☐ Diarrhea
☐ Hiatus Hernia	☐ Constipation	☐ Heart Burn	☐ Insomnia
☐ Inguinal Hernia	☐ Stomach Ulcer	☐ Sinusitis	☐ Allergies
☐ High Blood Pressure	☐ Varicose Veins	☐ Chest Pains	☐ Tendonitis
☐ Asthma	☐ Diabetes	☐ Headaches	☐ Jaw Pain
☐ PMS	☐ Lower Back Pain	☐ Dizziness	☐ Urinary frequency

☐ Numbness or tingling in the arms or legs

Other Health Problems?____

Previous Surgeries:___________________________________Date(s):____________________________

List of medication you are taking:____

Have you had any imaging taken? ☐ X-ray   ☐ CT   ☐ MRI ☐ Ultrasound ☐ Other:______________

Anything else you feel I should know?____

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Family History

Relation	Health Condition
Maternal Grandparents	
Paternal Grandparents	
Mother	
Father	
Brother	
Sister	

Social History

Do you smoke?____ If yes, how many packs a day?_________________

How often do you exercise? ____________________________ What do you do for exercise?_________________

Diet:
☐ Very Good ☐ Good ☐ Moderate ☐ Poor ☐ Very Poor

Vitamins and/or supplements you currently take:____