Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

ADULT INITIAL INTAKE FORM

PATIENT INFORMATION

Name: _____Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Emergency contact name and Ph. #: _____

Can Dr. Kassandre Goupil use your email address to contact you concerning your care? Y/N

How did you hear about this clinic: ❑ Walk by ❑ Website ❑ Flyer

❑ Referral: _____ ❑ Talks/events ❑ Other: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

MAIN HEALTH CONCERNS

My usual health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

When did the injury occur or condition develop?_____

How did the injury occur or condition develop?_____

Please indicate frequency of pain/discomfort: ❑ Constant ❑ Intermittent

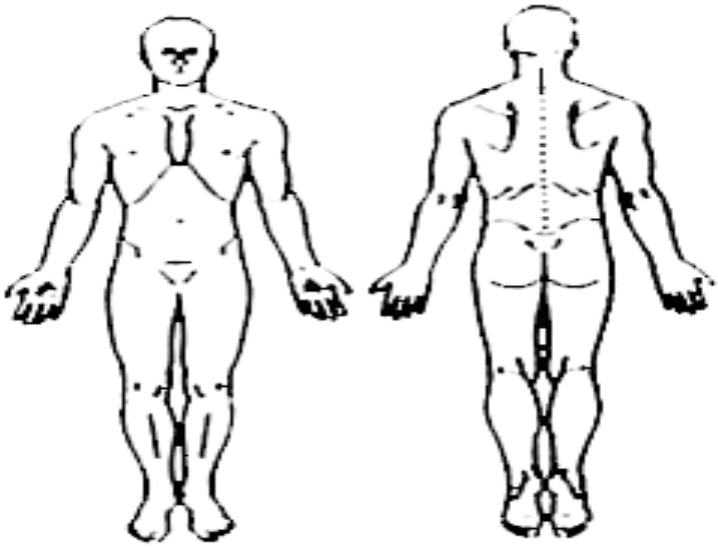
Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

PAIN & DISCOMFORT

Please indicate any areas of pain or discomfort on the diagram below (if applicable):



Describe your pain:

❑ Stiff/Tight ❑ Dull ❑ Sharp ❑ Shooting ❑ Burning ❑ Numb ❑ Other:_____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Eczema/Psoriasis:
Stroke:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Autoimmune disease:	Liver/Gallbladder issues or disease:
Thyroid issues or disease:	Kidney/Bladder issues or disease:
Stomach/Intestine issues or disease:	Mental Illness:
Male reproductive system issues:	Female reproductive system issues:

Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

_____

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, diagnostic ultrasounds, CTs, MRIs, etc.

Year: _____ Description:

_____

Year: _____ Description:

_____

Year: _____ Description:

_____

Year: _____ Description:

_____

Please list supplements you are currently taking:

1. _____ (Brand) (Supplement Name) (Daily Dose)
2. _____ (Brand) (Supplement Name) (Daily Dose)
3. _____ (Brand) (Supplement Name) (Daily Dose)
4. _____ (Brand) (Supplement Name) (Daily Dose)
5. _____ (Brand) (Supplement Name) (Daily Dose)
6. _____ (Brand) (Supplement Name) (Daily Dose)
7. _____ (Brand) (Supplement Name) (Daily Dose)
8. _____ (Brand) (Supplement Name) (Daily Dose)
9. _____ (Brand) (Supplement Name) (Daily Dose)
10. _____ (Brand) (Supplement Name) (Daily Dose)

Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

____ Alcohol
____ Artificial sweeteners
____ Candy or other sweets
____ Pop/soda
____ Chewing tobacco
____ Cigarettes
____ Cigars/pipes
____ Coffee
_____ Fast food
_____ Fried foods
_____ Processed foods
_____ Margarine/butter
_____ Milk/cheese/yogurt, etc.
_____ Non-herbal tea
_____ Refined flour
_____ Refined sugar
_____ Vitamins and minerals
_____ Water, distilled
_____ Water, tap
_____ Water, well
_____ Diet often (Y or N)

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month and dosage (if known):

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
____ Birth control
____ Chemotherapy
____ Cortisone
____ Diabetic medications
____ Diuretics
____ Heart medications
____ High blood pressure
____ Hormone Therapy
____ Laxatives
____ Insulin
____ Recreational drugs
____ Relaxants/Sleeping pills
____ Thyroid medication
____ Tylenol/acetaminophen
____ Ulcer medications
Other: _____

Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

Informed Consent and Request for Chiropractic Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Kassandre Goupil will discuss the potential benefits, risks and alternatives involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____	_____	_____
Printed Name	Signature	Date

Due to the high demand for chiropractic appointments, our office has put into place a cancellation policy that requires **24 hours** of notice. By allowing us 24 hours of notice of your cancellation, we are able to fill that appointment time with a patient in need of treatment.

In the event where you do not give us the 24 hours of notice, the cancellation fee for a chiropractic visit is **$25.00** if the appointment is canceled within 2-24 hours before the scheduled appointment. If the appointment is canceled within an hour before the scheduled appointment or is a "no show" the patient will pay the full fee**.** This fee is non-insurable and must be paid before your next appointment.

It is also important to arrive on time for your appointment. If you arrive late there may be a chance that you will not be able to receive treatment that day.

If you "no show" three consecutive chiropractic appointments with no call, email or other means of contacting our office, you will be officially discharged from Dr.Kass's care. At such time, at your request, Dr.Kass will give you your patient file and facilitate a transfer to another chiropractor.

Print Name:_____

Patient Signature:_____ Date:_____

Chiropractor Signature:_Dr.Kassandre Goupil_____ Date:_____