Box 2410 Humboldt, SK S0K 2A0
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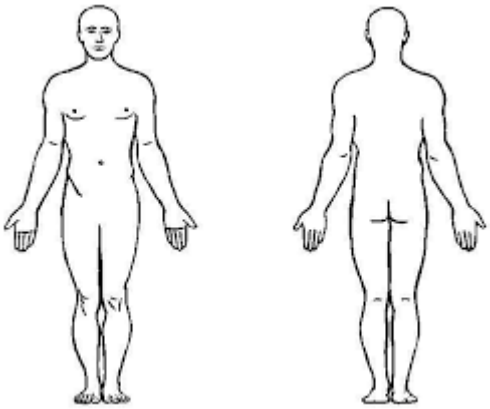
Injury Intake Form

Name: _____

Date of Injury/How long pain has persisted: _____

How did this injury occur? _____

Please circle which body part(s) is/are affected:



How would you rate your pain from 0-10 (0 being none, 10 being worst imaginable): ____

What improves the pain? _____What makes the pain worse? _____

What has your injury/pain held you back from doing (Work, hobbies, etc)?: _____
_____

Previous Medical History (Please check all that apply, past or present):

- ☐ Headaches
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Hypersensitivity to Heat/Cold
- ☐ Dizziness/Vertigo
- ☐ Heart Disease
- ☐ Memory Loss/ Feeling foggy
- ☐ Severe Nausea
- ☐ Depression
- ☐ Anxiety
- ☐ Incontinence
- ☐ Currently Pregnant
- ☐ Miscarriage
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Respiratory Disease
- ☐ Stroke
- ☐ Anorexia/Bulimia
- ☐ DVT
- ☐ Pacemaker
- ☐ Epilepsy
- ☐ Vision Problems
- ☐ Poor Circulation
- ☐ Surgical Implants
- ☐ Other: _____