

PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Ph. # _____ Cell Ph. # _____ Bus. Ph. # _____

E-Mail _____

Date of Birth (D/M/Y) ___/___/___ Gender M / F Age _____ Marital Status – S M C D W

Spouse's Name _____ Children _____

Occupation (Your) _____

Employer _____

Address _____

City _____ Phone _____

Emergency Contact _____ Phone _____

Provincial Health Card Number _____

Do you have extended health coverage? Yes No

We directly bill AB Blue Cross / Green Shield. Plan # _____ Group # _____

Who referred you to our office? _____

Have you had a recent motor vehicle accident (Yes No) or work related accident (Yes No)?

Reason for consulting our office: _____

Expectations: _____

PRIOR CHIROPRACTIC CARE:

Name: _____ Telephone: _____

X-rays taken: YES NO If yes, when: _____ What areas: _____

Results Achieved: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment: _____ Date of Last Physical: _____



PATIENT ENTRANCE FORM (continued)

MEDICAL SPECIALIST:

Name: _____ Telephone: _____

Specialty: _____ Date of Last Appointment: _____

DENTIST:

Name: _____ Telephone: _____

Location: _____ Date of Last Appointment: _____

DENTAL SPECIALIST:

Name: _____ Telephone: _____

Specialty: _____ Date of Last Appointment: _____

List Past Dental Procedures: _____

NATUROPATH:

Name: _____ Telephone: _____

Practice Location: _____

MASSAGE THERAPIST

Name: _____ Telephone: _____

Practice Location: _____

PHYSICAL THERAPIST:

Name: _____ Telephone: _____

Practice Location: _____

DIAGNOSTIC PROCEDURES:

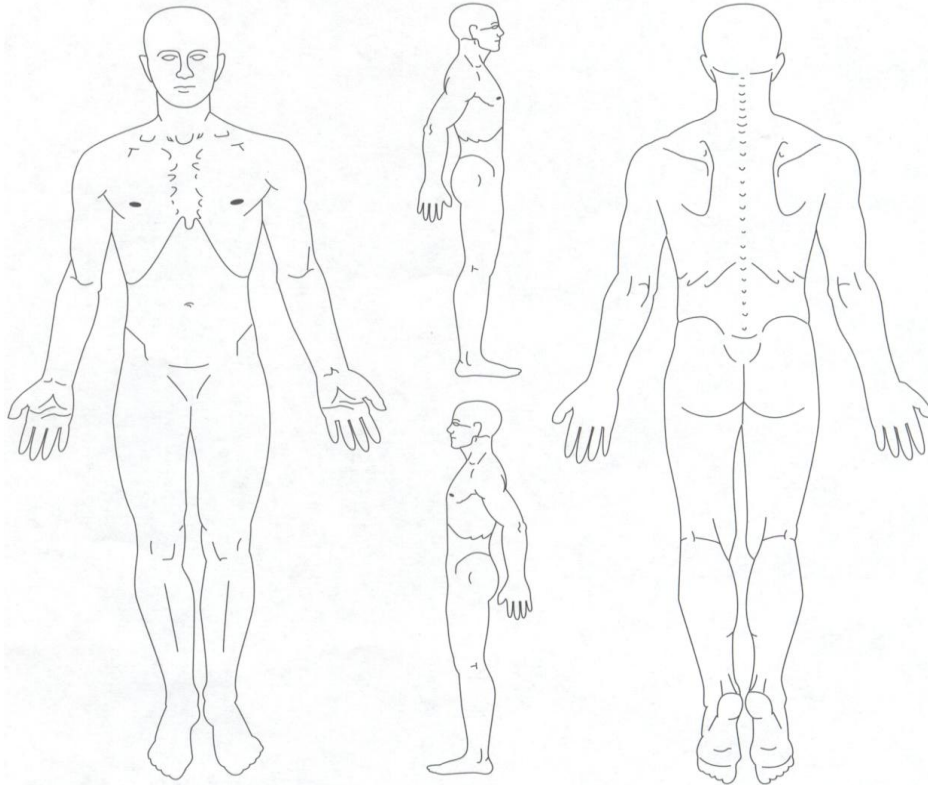
Please list X-ray, MRI, CT, and ultrasound studies that have been performed in the past 3 years:

Date:	Procedure:	Area Examined:	Results:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT ENTRANCE FORM (continued)

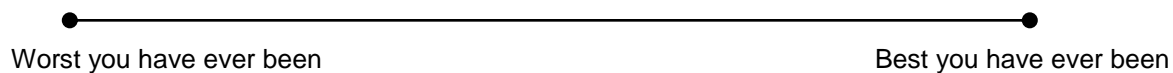
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Sharp
- T** = Tingling (Pins & Needles)
- C** = Cramping



Please reflect on your **sense of well-being**, taking into account your physical, mental, emotional, social, and spiritual condition **over the past one month**. Use an X on the line to mark your answer to the question.

Mark the line below with an X at the point that summarizes your **overall sense of well-being** for the past one month.



PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms that you have had within the last year.

C = Constant F = Frequent (weekly) O = Occasional (monthly/yearly)

C F O

NEUROLOGICAL

- allergy
- chills
- convulsions
- dizziness
- fainting
- fevers
- headaches
- loss of sleep
- nervousness
- depression
- neuralgia
- numbness
- sweats
- loss of weight
- tremors

MUSCLE & JOINT

- arthritis
- bursitis
- foot trouble
- hernia
- low back pain
- neck pain
- neck stiffness
- pain between shoulders

RESPIRATORY

- chest pain
- chronic cough
- difficulty breathing
- spitting blood
- throat phlegm
- wheezing

EYES, EARS, NOSE & THROAT

- colds
- crossed eyes
- deafness
- dental decay
- asthma
- ear aches
- ear noises

C F O

- sinus infections
- enlarged glands
- enlarged thyroid
- sore throat
- tonsillitis
- eye pain
- failing vision
- far sighted
- gum trouble
- hay fever
- hoarseness
- nasal obstruction
- near sighted
- nosebleeds

CARDIO-VASCULAR

- rapid heart beats
- slow heart beats
- swelling of ankle
- hardening of arteries
- high blood pressure
- low blood pressure
- pain over heart
- poor circulation

GASTRO INTESTINAL

- excessive hunger
- burping or gas
- liver trouble
- colitis
- colon trouble
- constipation
- diarrhea
- difficult digestion
- distension of abdomen
- stomach pain
- gall bladder trouble
- hemorrhoids
- intestinal worms
- jaundice
- poor appetite
- nausea
- vomiting
- vomit blood

SKIN

C F O

- boils
- bruise easily
- dryness
- hives or allergy
- itching
- skin rash
- varicose veins

GENITO-URINARY

- bed wetting
- blood in urine
- frequent urination
- loss control urine
- kidney infection
- painful urination
- prostate trouble
- pus in urine
- smell of urine

PAIN OR NUMBNESS IN:

- shoulders
- arms
- hands
- hips
- legs
- knees
- ankles
- feet
- painful tail bone
- sciatica
- swollen joints

FOR WOMEN ONLY

- cramps
- heavy flow
- light flow
- irregular cycle
- painful cycle
- discharge
- sore breasts

Menopausal: Yes No

Last menstruation date: _____

Pregnant: Yes No

Due date: _____

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: Yes No Alcohol Consumption: Yes No Rarely

Do you exercise: Yes No Exercise Activities: _____

Do you drink beverages with caffeine: Yes No If yes, how many cups/glasses daily: _____

How many glasses of water do you drink per day: 0 – 4 4 - 8 8 - 12 12+

Rate your sleep, hours per night: 4 - 6 6 - 8 8 - 10 12+

Do you wake rested: Yes No

Do you feel overly fatigued during the course of a day: Yes No

Rate your appetite: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Significant Falls and Accidents, list: _____

Have you ever been knocked unconscious: Yes No Don't know

If so, for how long: _____

Surgery and Operations, list: _____

List vitamins and minerals that you take: _____

List any medication (dosage/frequency) you are currently taking: _____

Have you previously been hospitalized: Yes No

Reason: _____

Any family health conditions or problems: Yes No

Please list: _____

Signature: _____ Date: _____

REVIEW OF CONDITIONS

(It is critical that you check all that apply)

HEADACHES:

How long have you had headaches? _____ Why did these headaches begin? _____
Do you consider this headache to be migraine neck related jaw related
 or other (list) _____
How long do the headaches last (give a number or range)? ____ hours ____ days
or it varies (explain) _____
 Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Front Back Left Side Right Side Entire Head
These headaches: are localized originate from another location (where?) _____
 travels to another location (where?) _____
Are there things that make your headache better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

CERVICAL (Neck):

How long have you had neck issues? _____ Why did this neck issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Top of neck Base of neck Left Side Right Side Entire Neck
The neck discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your neck discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

SHOULDERS:

How long have you had shoulder issues? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The shoulder discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your shoulder discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

THORACIC (MID BACK):

How long have you had mid back issues? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The mid back discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your low back discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

REVIEW OF CONDITIONS (cont'd)

(It is critical that you check all that apply)

LUMBAR (LOW BACK):

How long have you had low back issues? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The low back discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your low back discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

UPPER EXTREMITIES:

Area involved: shoulders upper arm elbow lower arm wrist hand
How long have you had this issue? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

HIPS:

How long have you had hip issues? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The hip discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your hip discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe

LOWER EXTREMITIES:

Area involved: hips thigh knee lower leg ankle foot
How long have you had this issue? _____ Why did this issue begin? _____
Please describe as: Ache Stiff Tight Spasm Sharp Numbness Other
How often does this pain occur? Constant Daily Weekly Monthly
 or is irregular (explain) _____
What area is involved? Left Right Both
The discomfort: is localized originates from another location (where?) _____
 travels to another location (where?) _____
Things that make your discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain |-----| Severe