Align Health & Wellness
Suite 226, 4411 – 16th Avenue NW, Calgary, Alberta T3B 0M3

PATIENT ENTRANCE FORM

Last Name: ____________________ First Name: ____________________ Date: ___________________________

____
Address City, Province Postal Code

Ph. # __________________ Cell # ____________________ Email ____

Prov. Health Card Number: ______________________

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

Spouse's Name ____ Children______________

Emergency Contact____ Phone _______________________

Occupation (Your) _____________________________ Employer ____

City ____ Phone _______________________

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 CHIROPRACTOR: ____ Phone: ___________________

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

Results Achieved: Excellent Good Fair Poor

MEDICAL DOCTOR: ____ Phone: ___________________

Date of Last Appointment: __________________________________ Date of Last Physical: ________________

MEDICAL SPECIALIST: ____ Phone: ___________________

Specialty: ____________________________________Date of Last Appointment: _________________________

DENTIST: ____ Phone: ___________________

Location: _____________________________________Date of Last Appointment: ________________________

DENTAL SPECIALIST: ____ Phone: ___________________

Specialty: ____________________________________Date of Last Appointment:__________________________

Past Dental Procedures: ____

Patient/Legal Guardian Signature: _______________________________________ Date: ____________________

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Last Name: ____________________ First Name: ____________________

NATUROPATH: ____ Phone: ___________________

Practice Location: ____

MASSAGE THERAPIST: ____ Phone: ___________________

Practice Location: ____

PHYSICAL THERAPIST: ____ Phone: ___________________

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:

____

____

____

DIRECT BILLING OPTIONS

Do you have extended health coverage? ☐ Yes☐ No

For direct billing to your insurance company:

MasterCard #______________________________ Exp. _________ Validation Code: _______
M M / Y Y

Visa #______________________________ Exp. _________ Validation Code: _______
M M / Y Y

Blue Cross Plan #______________________________ Group # __________

GreenShield Plan #______________________________ Group # __________

SSQ Plan #______________________________ Group # __________

Empire Life Plan #______________________________ Group # __________

Plan Member Name: ________________________________ Date of Birth: ____________________
D D / M M / Y Y Y Y

Relationship to Plan Member: ________________________________

Patient/Legal Guardian Signature: _______________________________________ Date: ____________________

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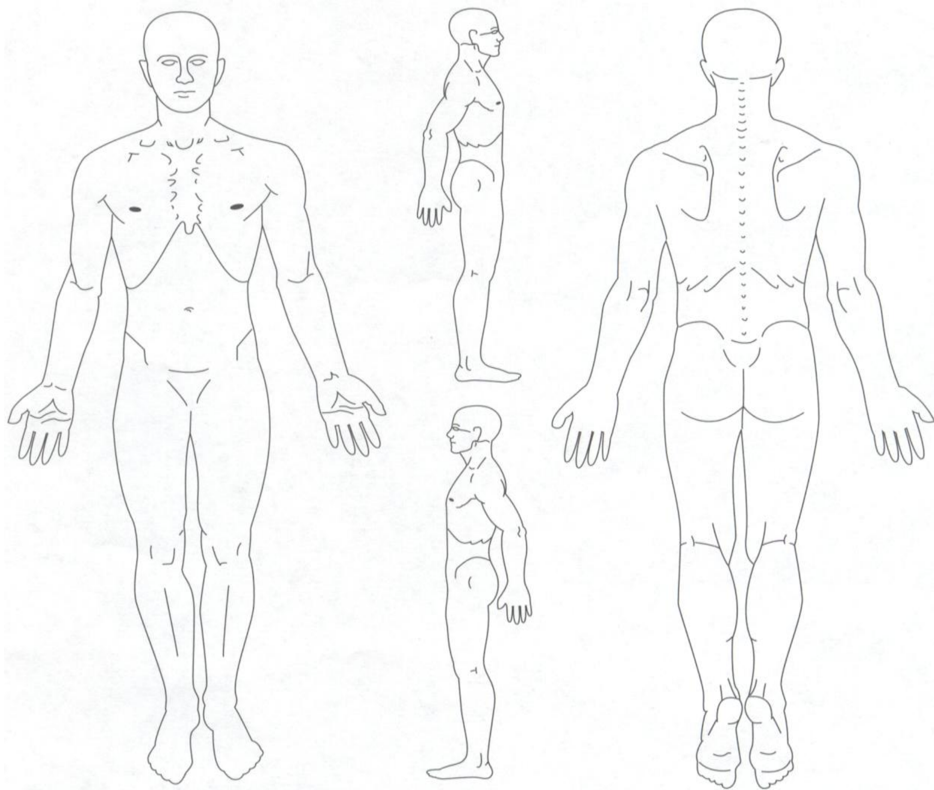
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

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.

Worst you have ever been — Best you have ever been

Patient/Legal Guardian Signature: ____ Date: ____________________

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PAST HISTORY (Please check appropriate box for any symptoms that you have experienced 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

C F O

SKIN

❑ ❑ ❑ 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/Legal Guardian Signature: ______________________________ Date: ____________________

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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: ____

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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?) ____
Things that make your headache better? ____________________ worse? ____________________
The average severity of the pain associated with this symptom:
No pain I---I 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 I---I 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 I---I 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 I---I Severe

Patient/Legal Guardian Signature: ____ Date: ____________________

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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 I---I Severe

UPPER EXTREMITIES: How long have you had this issue? ________ Why did this issue begin? _______________
Area involved: ❑ shoulders ❑ upper arm ❑ elbow ❑ lower arm ❑ wrist ❑ hand
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 I---I 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 I---I Severe

LOWER EXTREMITIES: How long have you had this issue? ________ Why did this issue begin? _______________
Area involved: ❑ hips ❑ thigh ❑ knee ❑ lower leg ❑ ankle ❑ foot
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 I---I Severe

Patient/Legal Guardian Signature: ____________________________________ Date: ____________________