Patient Entrance Form

Name _____ **Date** _____

Address _____ **Gender M F**

City, Province _____ Postal Code _____ E-Mail _____

Home Tel. _____ **Bus. Tel.** _____ **Cell** _____

Date of Birth _____ **Age** _____ **Marital Status** – S M D W CL S

Spouses Name _____ **Children** _____

Occupation (Your) _____

Employer _____

Address _____

City _____ **Phone** _____

Closest Relative (Relationship) _____

Health card # _____

How did you hear about this office:

Friend (Name) _____ **Phone Book** _____ **Sign** _____ **Other** _____

Claim Will Be Made Against:

1. Recent Motor Vehicle Accident: Yes No If Yes, Please Fill Out Insurance Form

2. Work Related Injury/Accident: Yes No If Yes, Please Fill Out WSIB Form

Prior Chiropractic Care:

Dr.'s Name _____ Phone _____ Last Visit _____

X-Rays Taken Yes No Date: _____ Results: Excellent Good Fair Poor

Medical Doctor:

Name _____ Telephone _____

Address _____

Date of Last Appointment: _____ Date of Last Physical _____

Reason for consulting this office: _____

_____

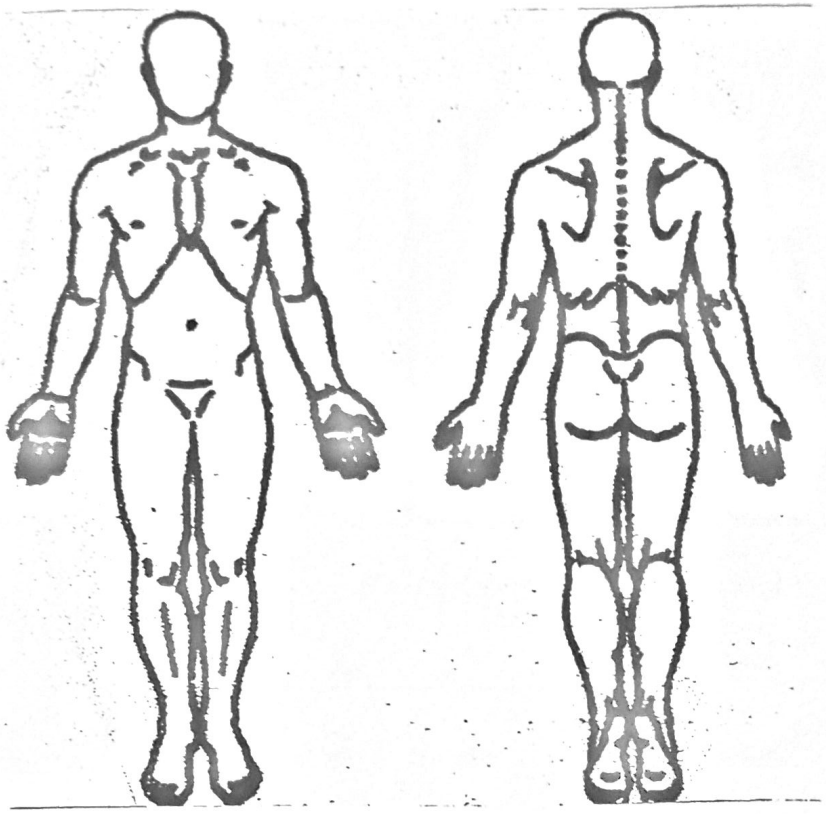
Expectations:

_____

_____

Show area(s) of pain or unusual feeling using the below symbols, mark the areas on this figure where you feel the sensations.

Numbness --------
Pins & Needles +++++
Burning XXXXX
Aching ******
Stabbing //////////



Pain Scale:
Rate the severity of your pain by placing an X on the line on the following scale.

No pain 1 2 3 4 5 6 7 8 9 10 excruciating

Have you ever had any of the following: (please check)

Aneurysm____ Osteoporosis___ Diabetes____ Arthritis____
Respiratory conditions____ Epilepsy____ Cancer____
Strokes____ Allergies____ Heart Conditions____ Hepatitis____
Nerves____ Fatigue____ Polio____ Sleep Difficulty____
Pneumonia____ Pleurisy____ Asthma____ V.D____
Psoriasis____ HIV____ Sinus Conditions____

Childhood conditions: (please check)

Measles____ Mumps____ Chicken pox____ Whooping cough____
Scarlet fever____ Diphtheria____ Rheumatic fever____ Typhoid fever____
Ear Infections____ Tubes in ears____ Chronic illness____

PATIENT PAST HISTORY FORM

NAME:_____DATE:_____

PLEASE CHECK OFF ANY OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE, OR HAVE HAD IN THE PAST.

C = CONSTANT F = FREQUENT O = OCCASIONAL

C F O

NEUROLOGICAL

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

MUSCLE & JOINT PAIN

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

RESPIRATORY

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

EYES, EARS, NOSE & THROAT

O O O colds
O O O crossed eyes
O O O deafness
O O O dental decay
O O O asthma
O O O ear aches
O O O ear discharge
O O O ear noises

C F O

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

CARDIO-VASCULAR

O O O rapid heart beats
O O O slow heart beat
O O O swelling of ankles
O O O hardening of arteries
O O O high blood pressure
O O O low blood pressure
O O O pain over heart
O O O poor circulation

GASTRO INTESTINAL

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

C F O

SKIN

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

GENITO-URINARY

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

PAIN OR NUMBNESS IN:

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

FOR WOMEN ONLY

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

menopausal: yes no
last menstruation date:_____
pregnant: yes no
due date_____

PATIENT PAST HISTORY (continued)

HABITS OF LIFESTYLE:

DO YOU SMOKE: YES NO DO YOU CONSUME ALCOHOL: YES NO

DO YOU EXERCISE: YES NO EXERCISE INDOOR ACTIVITIES_____

EXERCISE OUTDOOR ACTIVITIES_____

RATE YOUR SLEEP, HOURS PER NIGHT: 4 - 6 6 - 8 8 - 10 12 +

DO YOU WAKE RESTED: YES NO

RATE YOUR APPETITE: POOR FAIR MEDIUM GOOD EXCELLENT

RATE YOUR DIET: POOR FAIR MEDIUM GOOD EXCELLENT

DO YOU EAT REGULARLY: BREAKFAST LUNCH DINNER

DO YOU EAT PER DAY: 1 MEAL 2 MEALS 3 MEALS 4 MEALS MORE THAN 4 MEALS

DATE OF LAST DENTAL EXAMINATION:_____

FALLS AND ACCIDENTS - LIST: _____

_____

SURGERY AND OPERATIONS - LIST:_____

_____

SURGERY RECOMMENDED BUT NOT PERFORMED - LIST:_____

_____

DO YOU TAKE VITAMINS AND MINERALS - LIST:_____

_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS: YES NO DON'T KNOW

IF SO, FOR HOW LONG:_____

LIST ANY MEDICATION OR DRUGS YOU ARE CURRENTLY TAKING:_____

_____

_____

HAVE YOU PREVIOUSLY BEEN HOSPITALIZED: YES NO

PLEASE LIST:_____

ANY FAMILY HEALTH CONDITIONS:_____

PLEASE LIST:_____

_____