

PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Tel _____ Cell _____ Email _____

Date of Birth (M/D/Y) _____ Age _____ Marital Status - S M D W S

Spouse's Name _____

Occupation (Your) _____

Employer _____

Address _____

City _____ Phone _____

Closest Relative _____ Phone _____

Provincial Health Card Number: _____

Extended Health Care Company: _____

Policy # _____

How did you hear about our office: friend phone book sign other _____

CLAIM WILL BE MADE AGAINST:

- | | | | |
|-----------------------------------|-----|----|------------------------|
| 1. Recent motor vehicle accident: | Yes | No | (if Yes, see attached) |
| 2. Work related injury/accident | Yes | No | (if Yes, see attached) |

PRIOR CHIROPRACTIC CARE:

Name: _____ Telephone: _____

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: _____

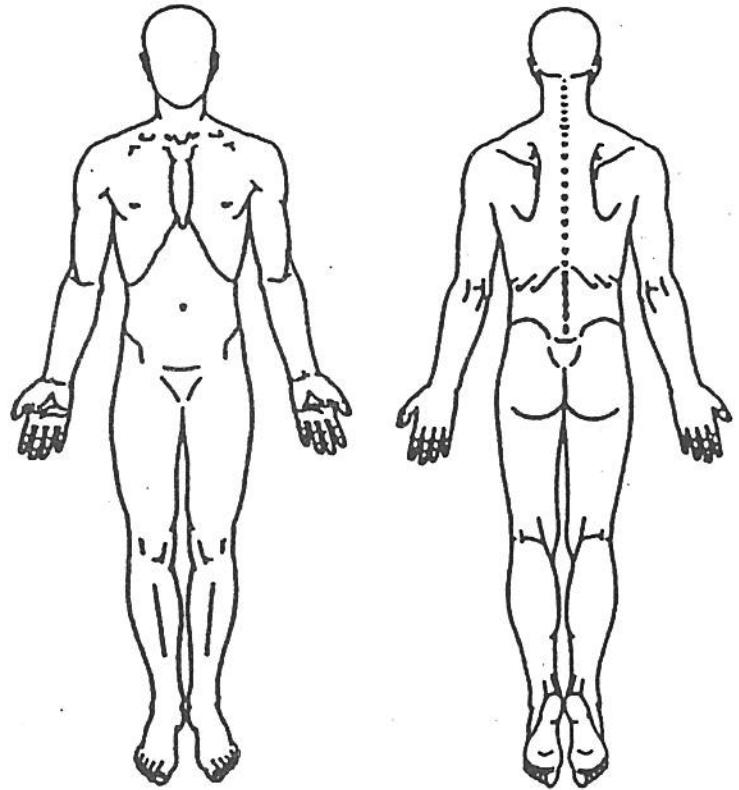
Expectations: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

- Numbness ● ● ● ● ●
- ● ● ● ●
- ● ● ● ●
- Pins & Needles 0 0 0 0 0
- 0 0 0 0 0
- 0 0 0 0 0
- Burning X X X X X
- X X X X X
- X X X X X
- Aching * * * * *
- * * * * *
- * * * * *
- Stabbing / / / / /
- / / / / /
- / / / / /



Have you ever had any of the following:

- aneurysm _____ osteoporosis _____ diabetes _____ arthritis _____
- respiratory conditions _____ epilepsy _____ cancer _____
- strokes _____ allergies _____ heart conditions _____
- hepatitis _____ nerves _____ fatigue _____ polio _____
- sleeping difficulty _____ pneumonia _____ pleurisy _____
- asthma _____ STI _____ psoriasis _____ HIV _____
- sinus conditions _____

Childhood conditions had, please check:

- measles mumps chicken pox whooping cough
- scarlet fever diphtheria rheumatic fever typhoid fever
- ear infections tubes in ears chronic ill

PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O F C

- 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 discharges
- ear noises

O F C

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

CARDIO-VASCULAR

- rapid heart beats
- slow heart beat
- swelling of ankles
- 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

O F C

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 menstration date: _____

Pregnant: Yes No

due date: _____

PATIENT PAST HISTORY FORM (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: Yes No

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 or problems: Yes No

Please list: _____

Signature: _____

Date: _____