PATIENT ENTRANCE FORM

Name ____ Date ______________

Address ____

City, Province ______________________________ Postal Code ________________________

Home Tel __________________ Bus. Tel. __________________

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

Spouse's Name ______________________________ Children ________________________

Occupation (Your) ____

Employer ____

Address ____

City ____ Phone ______________

Closest Relative ______________________________________ Phone ______________

Provincial Health Card Number ______________________________ Letter Code ______________

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: ____________________

Side 1

Reason for consulting this office: ______________________________

____

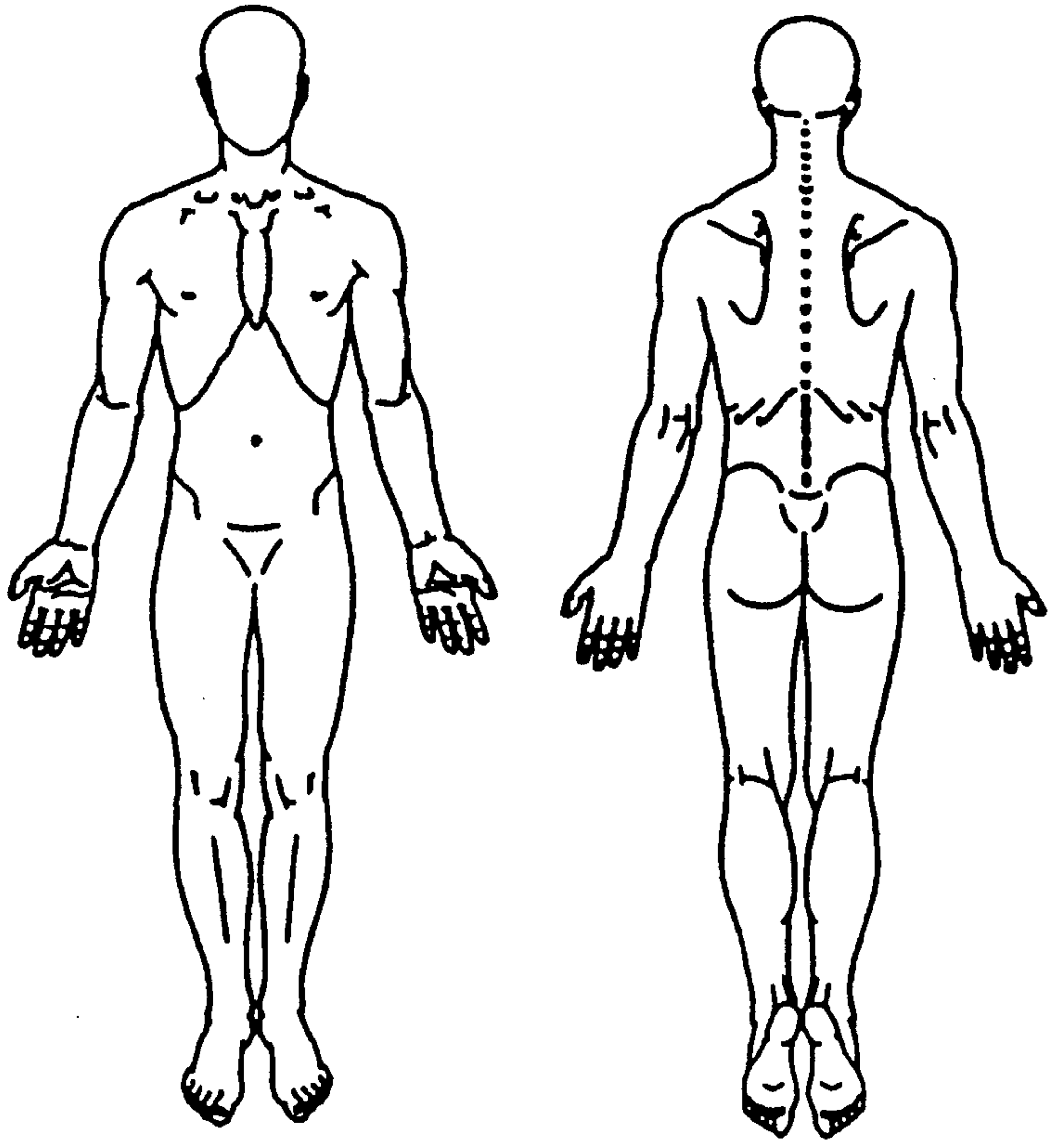
____

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 ________ ostheoporosis ________ diabetes ________ arthritis ________

respiratory conditions ________________ epilepsy ________ cancer ________

strokes ________ allergies ________ heart conditions ________________

hepatitis ________ nerves ________ fatigue ________ polio ________

sleeping difficulty ________________ pneumonia ________ pleurisy ________

asthma ________ V.D. ________ 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

- ☐ ☐ ☐ bet 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: ______________

SIDE 1

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 Oudoor 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: ____________________