

PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Tel. _____ Bus. Tel. _____ E-Mail _____

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

Spouse's Name _____ Children _____

Occupation (Your) _____

Employer _____

Address _____

City _____ Phone _____

Emergency Contact _____ Phone _____

Provincial Health Card Number _____

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:

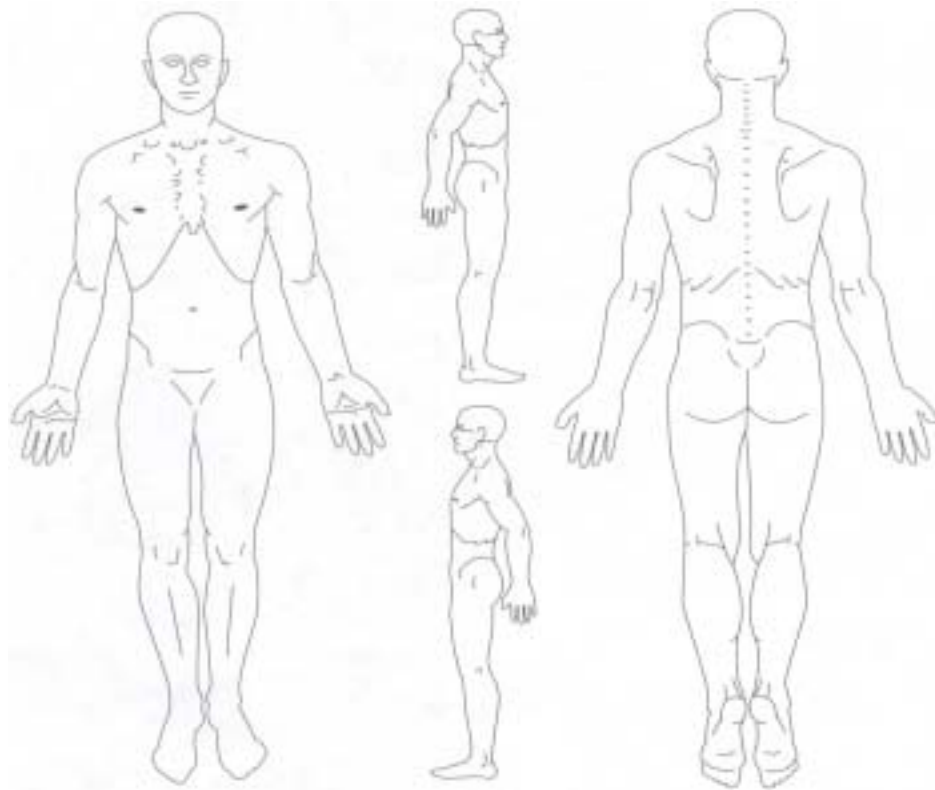
Please list X-ray, MRI, CT, and ultrasound studies that have been performed in the past 3 years:

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

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 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

- 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 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: _____