Consultation Admittance Form

Last Name:		First Name:	Gender: M / F
Address:		City, Province:	Postal Code:
Phone: (Home) ( )		Phone: (Work) ( )	Phone: (Cell) ( )
Alberta Health Care #:		How did you hear about us?	
Date of Birth:	Age:	Height:	Weight:
Occupation:		Marital Status: Single Married Widowed Divorced	
# Children & Ages:			
Emergency Contact Name:		Emergency Contact Phone: ( )	

Please check all answers and fill in the blanks where appropriate.

Reason(s) for appointment: _____

When did your condition begin? _____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when?_____

_____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur?

_____

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? _____

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____

Date:_____ _____

Family doctor name: Dr. _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.:

_____

_____

Date: _____ Patient signature:_____

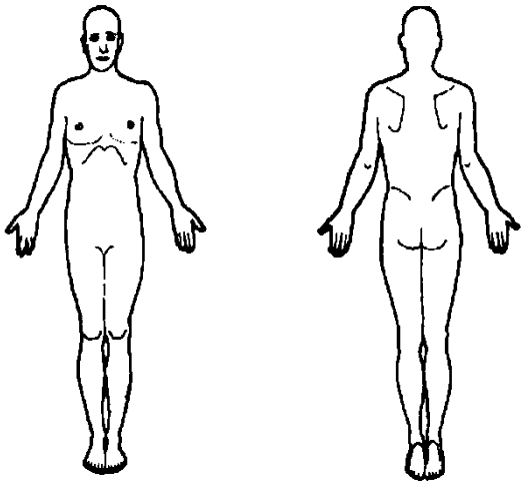
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------- Yes No
2. Hardening of the arteries (arteriosclerosis)---------- Yes No
3. Diabetes---------- Yes No
4. Tuberculosis---------- Yes No
5. Cancer---------- Yes No
   Where? _____
6. Heart or blood diseases---------- Yes No
7. Bone spurs on the neck bones (cervical sprain)---------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From_____ to _____ _____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision)---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
14. Slurred speech or other speech problems ---------- Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------- Yes No
19. Sudden collapse without loss of consciousness---------- Yes No
20.

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |
No pain Extreme pain

Systems Review

Patient Name:_____ **Date:**_____ _____

_____

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**

Eye pain
Double vision
Ringing in ears
Deafness
Nosebleeds
Trouble swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

Neck pain
Low back pain
Arm pain
Shoulder pain
Leg pain
Knee pain
Foot pain
Pain/numbness down arms or legs
Pain between shoulders
swollen joints
Spinal curvature
Arthritis
Fractures

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week?
Other: