PATIENT ENTRANCE FORM

Date: _____ Name: _____

Home Phone: _____ Work Phone: _____

City: _____ Street: _____

Province: _____ Postal Code: _____

Email: _____ Date of Birth: _____

Occupation: _____ No. of Children: _____

Medical Dr: _____ Insurance Provider: _____

How did you hear about our office? _____

Would you like to receive email communication? ☐ Yes ☐ No

Is this a work related accident? (WCB) ☐ Yes ☐ No
Are the injuries the result of a motor vehicle accident? ☐ Yes ☐ No
Do you have a private health care insurance plan? ☐ Yes ☐ No
Do you wear orthotics? ☐ Yes ☐ No

HEALTH PROFESSIONAL INFORMATION

What Health Professionals have you seen previously?

☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Acupuncturist

Health Professional: _____

What were you treated for? _____

Were x-rays taken? _____ What is you major complaint? _____

How long have you had this condition? _____

Have you had this similar condition in the past? ☐ Yes ☐ No When? _____

Please list any surgical operations and the years in which they were performed _____

Are you currently taking:

☐ Birth Control ☐ Insulin
☐ Tranquilizers ☐ Pain Killers
☐ Blood Pressure Pills ☐ Muscle Relaxants
☐ Vitamins ☐ Other:

FAMILY MEDICAL HEATH INFORMATION

Many health problems are the result of hereditary weakness. This information about your **immediate family members** will give us a better picture of your total health.

Do you or a family member have a history of the following?

☐ Aids ☐ Allergies ☐ Asthma ☐ Learning Disability
☐ Heart Disease ☐ Depression ☐ Diabetes ☐ Epilepsy
☐ Multiple Sclerosis ☐ Cancer ☐ Other:

The following is a list of conditions which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and the possibility of being accepted for care.

Check any of the following you have or have had in the past:

☐ Tuberculosis ☐ Alcoholism ☐ Eczema/Psoriasis ☐ Anaemia
☐ Diabetes ☐ Cancer ☐ Arthritis ☐ Goiter
☐ Heart Disease ☐ Epilepsy ☐ Pneumonia ☐ Osteoporosis
☐ Mental Disorder ☐ Influenza ☐ Polio

Check any of the following you have or have had in the past 6 months:

Musculoskeletal
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Walking Problems
- ☐ Joint Pain/Stiffness
- ☐ Difficult Chewing/Clicking Jaw
- ☐ Leg Pain

Cardiovascular
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heart Beat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Ankle Swelling

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Females Only: When was your last period? _____

Are you pregnant? ☐Yes ☐No
- ☐Menstrual Irregularity
- ☐Menstrual Cramping
- ☐Breast Pain

Male Only: ☐Prostate/Sexual Dysfunction

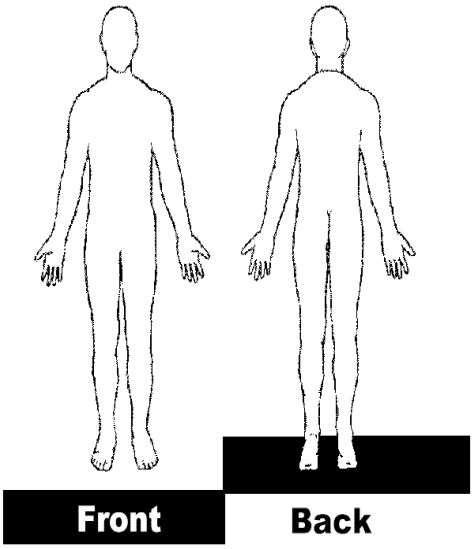
Genito-Urinary
- ☐Bladder Trouble
- ☐Painful/Excessive Urination
- ☐Discoloured Urine

Nervous System
- ☐Numbness
- ☐Paralysis
- ☐Dizziness
- ☐Convulsions
- ☐Cold/Tingling Extremities
- ☐Fainting

General
- ☐Loss of Sleep
- ☐Fever
- ☐Headaches

Gastro-Intestinal
- ☐Poor/Excessive Appetite
- ☐Excessive Thirst
- ☐Heart Burn
- ☐Vomiting
- ☐Liver Trouble
- ☐Gas Bloating After Meals
- ☐Black/Bloody Stool
- ☐Nausea
- ☐Constipation
- ☐Diarrhea
- ☐Colitis

Please outline on the diagram the area of discomfort:



Patient's signature: _____ Witness: _____ Date: _____

Guardian's Signature: _____ Witness: _____ Date: _____