# Consultation Admittance Form

| Last Name: | | First Name: | | Gender: M / F |
|---|---|---|---|---|
| Address: | | City, Province: | | Postal Code: |
| Phone (Home) ( ) | | Phone (Work) ( ) | | Phone (Cell) ( )<br>Provider (eg. Bell, Fido, etc.) |
| Alberta Health Care # | | Third Party Insurance # | | |
| Emergency Contact Name: | | Emergency Contact Phone ( ) | | |
| Date of Birth: | Age: | Height: | Weight: | |
| Occupation: | | Marital Status: Single Married Widowed Divorced | | |
| Email address: (optional) | | Email will be used for appointment reminders, receipts, occasional health info, etc. You may unsubscribe anytime. | | |
| How did you learn of our clinic? | | Did anyone refer you? If Yes, who? | | |

**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: Dr. ___________________________________ Phone:__________________ Clinic:______________________

Would you like us to contact your family doctor regarding your clinical findings, treatments plan and progress? Yes / No

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

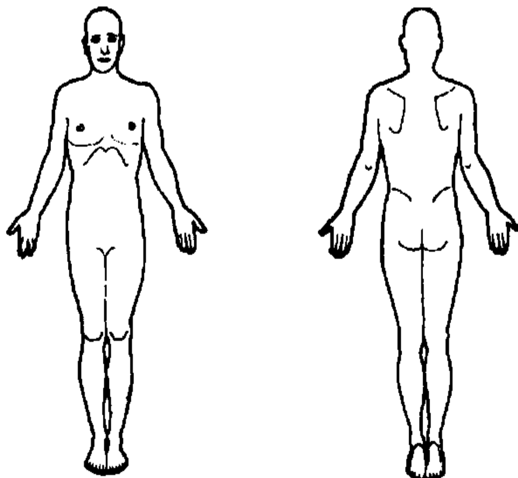
Date: Patient signature:

# 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



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<br>Sweats<br>Fainting<br>Sleep disturbance<br>Fatigue<br>Nervousness<br>Weight loss<br>Weight gain | Chronic cough<br>Spitting up phlegm<br>Spitting up blood<br>Chest pain<br>Wheezing<br>Difficulty breathing<br>Asthma | Frequent urination<br>Painful urination<br>Blood in urine<br>Pus in urine<br>Kidney infection<br>Prostate trouble<br>Uncontrollable urine flow |
| **NEUROLOGICAL** | **CARDIOVASCULAR** | **GASTROINTESTINAL** |
| Visual disturbance<br>Dizziness<br>Fainting<br>Convulsions<br>Headache<br>Numbness<br>Neuralgia (nerve pain)<br>Poor coordination<br>Weakness<br>Vertigo | Rapid beating heart<br>Slow beating heart<br>High blood pressure<br>Low blood pressure<br>Pain over heart<br>Hardening of arteries<br>Swollen ankles<br>Poor circulation<br>Palpitations<br>Cold hand or feet<br>Varicose veins | Poor appetite<br>Difficult digestion<br>Heartburn<br>Ulcers<br>Nausea<br>Vomiting<br>Constipation<br>Diarrhea<br>Blood in stool<br>Gallbladder/jaundice<br>Colitis |
| **EYES, EARS, NOSE, THROAT** | **MUSCLE & JOINT** | **FOR WOMEN ONLY** |
| Eye pain<br>Double vision<br>Ringing in ears<br>Deafness<br>Nosebleeds<br>Trouble swallowing<br>Hoarseness<br>Sinus infection<br>Nasal drainage<br>Enlarged glands | Neck pain<br>Low back pain<br>Arm pain<br>Shoulder pain<br>Leg pain<br>Knee pain<br>Foot pain<br>Pain/numbness down arms or legs<br>Pain between shoulders<br>swollen joints<br>Spinal curvature<br>Arthritis<br>Fractures | Painful menstruation<br>Hot flashes<br>Irregular cycle<br>Cramps or back pain<br>Vaginal discharge<br>Nipple discharge<br>Lumps in breast<br>Menopausal symptoms<br>Birth control pills<br>Miscarriages<br>Complications with pregnancy<br>Pregnant? Y / N Week?<br>Other: |

My signature below indicates that I attest that the information indicated here in these forms is correct. I further understand that none of my health information will be released by the Chiropractic Wellness Clinic to anyone without my written authorization to do so along with the specific information I wish to share.

X______________________________________ Date:___________________