PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Home Tel _____ Business Tel _____ E-mail _____

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

Spouse's Name _____ Children _____

Occupation (Your) _____

Employer _____

Address _____

City _____ Phone _____

Closest Relative (or contact) _____ Phone _____

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: _____

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment _____ Reason _____

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 of radiation. Include all affected areas.

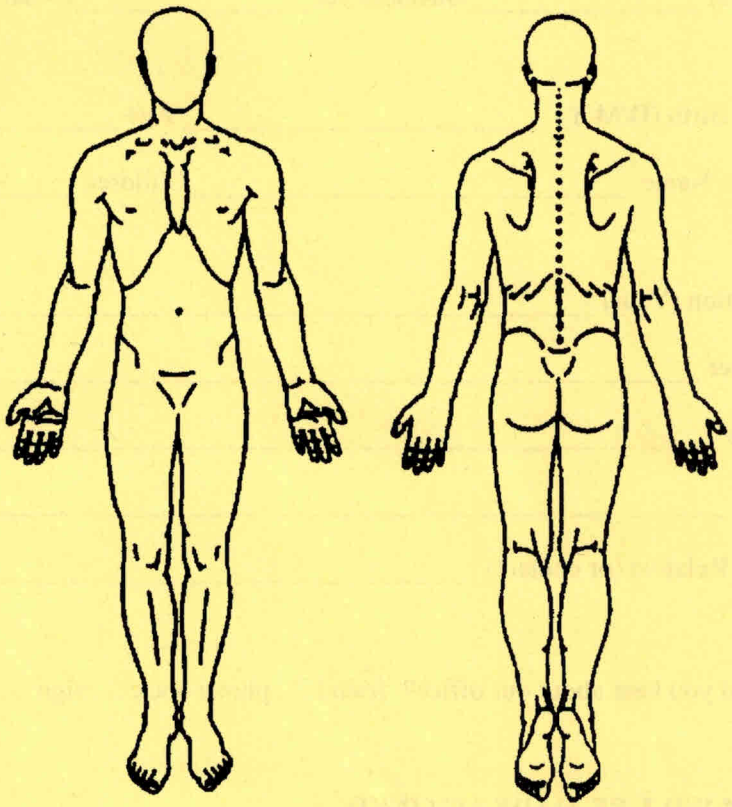
Numbness • • • • •
• • • • •
• • • • •

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 _____ osteoporosis _____ 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 illness