PATIENT ENTRANCE FORM

Date: ___________________________

Name (Last, First): __________________________________ (Male/ Female/Unspecified)

Address: ____

City/ Province: _____________________________________ Postal Code: __________________

Phone:____

Home Cell Work

Email: ____

Date of Birth (D/M/Y): ______________________________________ Age:______

Occupation: ______________________________ Employed By: _____________________________

Spouse's Name: _______________________________ Number of Children: ______

Albert Health Care Number: ____________________________________

How did you hear about our office?: □ referred by: ____________________________

□ social media: ___________________________

□ other: __________________________________

If this is a <u>work related injury</u> (WCB), please see the receptionist immediately

If this is an <u>Automobile Accident Insurance Claim</u>, please see the receptionist immediately

HEALTH HISTORY

It is very important that you give us accurate and complete information about your medical history and condition as treatment or procedures recommended will be based on such information.

PRIOR CHIROPRACTIC CARE

Chiropractor's Name: Dr.__________________________ Town/City:_________________________

X-Rays Taken: □ No □Yes, date taken: ________________________________

MEDICAL DOCTOR

Medical Doctor's Name: Dr.________________________________

Phone:____________________________

Date of Last Physical: ___________________________

Name:
Date:

REASON FOR SEEKING CARE

Please state your main reason for contacting The Wellness Centre:____

____

What goal(s) or stage(s) of care are you hoping to achieve?

□ **Stage 1:** Pain & Symptom Relief

□ **Stage 2:** Corrective Care (correct the root cause of the problem(s)

□ **Stage 3:** Wellness/Maintenance Care (optimize function, performance, and health)

□ Other:________________________________

When did you start to have the symptom(s)? ____

□ I do not have any symptom(s).

How did the symptom(s) start? Can you identify a reason for the symptom(s)?

____

____

If you have had these symptom(s) before, please describe: ____

____

Have you seen any other health care providers for this complaint? □ No □ Yes – *If yes, list the type of provider:* ____

Severity of Complaint

On a scale of 1 – 10, 10 being the worst pain, what is the level of pain/discomfort? _______________

Does the pain wake you up? □ No □ Yes - *If yes, does it keep you from sleeping? □ No □ Yes*

Quality

Which best describes the type of symptoms? *check all that apply*

□ Dull ache □ Sharp □ Deep □ Superficial □ Burning □ Numbness □ Shooting □ Tingling
□ Stiff □ Tight □ Other**:** ____

Aggravating Factors

What makes the symptom(s) feel worse?____

____

Relieving Factors

What makes the symptom(s) feel better? ____

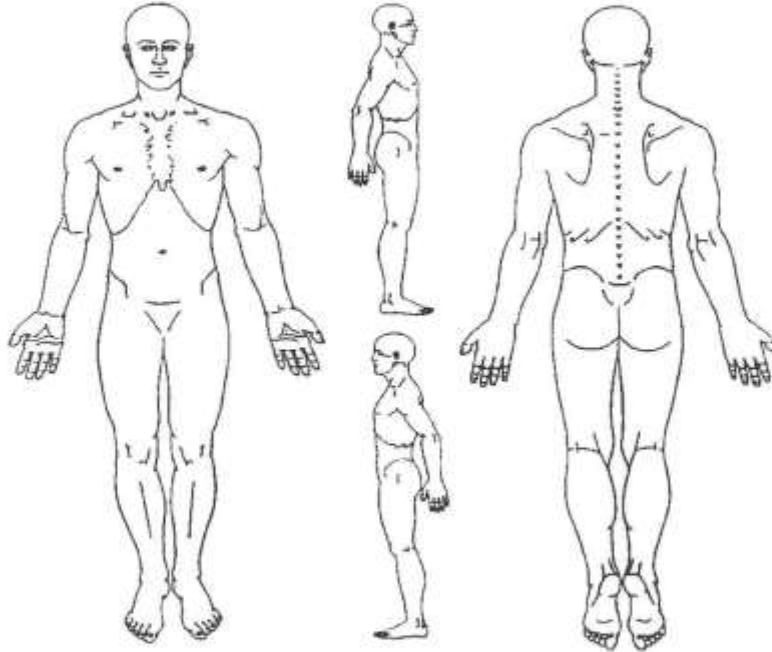
____

Name:
Date:

PATIENT SURVEY

Indicate below, the location and type of pain that is current or ongoing

Dull	Aching	Stiffness	Sharp/Stabbing	Burning	Numbness
*Mark with '**D**'*	*Mark with **'A'***	*Mark with '**S**'*	*Mark with '**P**'*	*Mark with '**X**'*	*Mark with '**N**'*



PATIENT HISTORY

List any prior or scheduled surgeries/ operations: ____

Have you ever been knocked unconscious? □ No □ Yes

Have you ever been hospitalized? □ No □ Yes

Do you have any of the following? *check all that apply*

□ Allergies	□ Aneurysm	□Chronic Fatigue	□ Arthritis	□ Venereal Disease
□ Cancer	□ Diabetes	□ Fibromyalgia	□ Epilepsy	□ Sinus Conditions
□ Fatigue	□ Hepatitis	□ Psoriasis	□ Depression	□Osteoporosis/Osteopenia
□ HIV/AIDS	□ Pneumonia	□ Heartburn	□ Irritable Bowel	Other: ________________

Are you using? □ Custom made orthotics □ Insoles □ Arch supports □ Heel lifts

Name:
Date:

Please check the appropriate box for any of the following symptoms which you now have or have had previously: O= Occasional, F= Frequent, C=Constant

SKIN					
O/F/C		**O/F/C**		**O/F/C**	
□ □ □	allergy	□ □ □	Boils	□ □ □	Bruise easily
□ □ □	Dryness	□ □ □	Hives	□ □ □	Itching
□ □ □	Skin rash	□ □ □	Varicose veins	□ □ □	
GENITO-URINARY					
□ □ □	Bed wetting	□ □ □	Blood in urine	□ □ □	Frequent urination
□ □ □	Loss of urine control	□ □ □	Kidney infection	□ □ □	Painful urination
□ □ □	Prostate trouble	□ □ □	Pus in urine	□ □ □	Smell of urine
MUSCLE & JOINT					
□ □ □	Tremors	□ □ □	Arthritis	□ □ □	Bursitis
□ □ □	Foot trouble	□ □ □	Hernia	□ □ □	Low back pain
□ □ □	Neck pain	□ □ □	Neck stiffness	□ □ □	Pain between shoulders
RESPIRATORY					
□ □ □	Chest pain	□ □ □	Wheezing	□ □ □	Chronic cough
□ □ □	Difficulty breathing	□ □ □	Spitting blood	□ □ □	Throat phlegm
EYES, EARS, NOSE & THROAT					
□ □ □	Colds	□ □ □	Tonsillitis	□ □ □	Sinus Infection
□ □ □	Hay fever	□ □ □	Hoarseness	□ □ □	Sore throat
□ □ □	Enlarged glands	□ □ □	Eye pain	□ □ □	Failing vision
□ □ □	Far sighted	□ □ □	Near sighted	□ □ □	Ear aches
□ □ □	Ear discharge	□ □ □	Ear noises	□ □ □	Deafness
□ □ □	Crossed eyes	□ □ □	nosebleeds	□ □ □	Gum trouble
GASTROINTESTINAL					
□ □ □	Vomiting	□ □ □	Vomit blood	□ □ □	Nausea
□ □ □	Excessive hunger	□ □ □	Burping/gas	□ □ □	Liver trouble
□ □ □	Colitis	□ □ □	Colon trouble	□ □ □	Constipation
□ □ □	Difficult digestion	□ □ □	Diarrhea	□ □ □	Distention of Abdomen
□ □ □	Stomach pain	□ □ □	Hemorrhoids	□ □ □	Gall bladder trouble
□ □ □	Intestinal worms	□ □ □	Jaundice		
CARDIO, BRAIN & NERVOUS SYSTEM					
□ □ □	Rapid heart rate	□ □ □	Slow heart rate	□ □ □	Swelling of ankles
□ □ □	Hardening of arteries	□ □ □	Heart pain	□ □ □	High blood pressure
□ □ □	Low blood pressure	□ □ □	Poor circulation	□ □ □	Neuralgia
□ □ □	Chills/Sweats	□ □ □	Convulsions	□ □ □	Dizziness
□ □ □	Fainting	□ □ □	Fevers	□ □ □	Headaches
□ □ □	Loss of sleep	□ □ □	Nervousness	□ □ □	Depression
PAIN or NUMBNESS					
□ □ □	Shoulders	□ □ □	Arms	□ □ □	Hands
□ □ □	Hips	□ □ □	Legs	□ □ □	Knees
□ □ □	Ankles	□ □ □	Feet	□ □ □	Tailbone
□ □ □	Sciatica	□ □ □	Swollen joints	□ □ □	

Name:
Date:

FOR WOMEN ONLY					
O/F/C		**O/F/C**		**O/F/C**	
□ □ □	Cramps	□ □ □	Heavy flow	□ □ □	Light flow
□ □ □	Irregular cycle	□ □ □	Painful cycle	□ □ □	Discharge
□ □ □	Sore breasts				
	Menopausal □ No □ Yes				
	Pregnant □ No □ Yes, due date:_________________________				

HABITS OF LIFESTYLE & WELLNESS QUESTIONNAIRE

Please answer the following questions on a scale of 1-10, 10 being the best:

General level of well-being _____ General outlook and attitudes (mental/emotional health) ______

In the past 30 days, how many days have you felt healthy and full of energy? _______

In the past 30 days, how many days was your physical health not good? _______

Average level of stress on a scale of 1-10, 10 being the most stress: _______

Hours slept per night: □ 4-6 □ 6-8 □ 8-10 □ 10+

Do you wake rested? □ Rarely □ Seldomly □ Usually □ Always

Do you exercise? □ No □ Yes - *If yes, please check all that apply*

□ Cardio/Aerobic □ Strength/Resistance □ Flexibility/Stretching □ Balance □ Sports/Leisure

List all Prescription or Over the Counter (OTC) medications, supplements, vitamins, and other natural herbals or remedies:

____

____

Do you think you may need to take vitamins, minerals or natural supplements?: □ No □ Yes

If yes, is there any particular area(s) of concern? ____

Rate your appetite: □ Poor □ Average □ Excessive

Rate your diet: □ Poor □ Average □ Exceptional

Meals eaten per day: □ 1 □ 2 □ 3 □ 4+

Daily water consumption: □ 0-4 cups □ 4-7 cups □ 8+ cups

Daily coffee consumption: □ 0 □ 1-4 cups □ 5+ cups

Daily pop/energy drink consumption: □ 0 □ 1-4 cans □ 5- cans

Do you consume alcohol? □ None □ Light □ Moderate □ Heavy

Do you use tobacco products? □No □Yes – *If yes, amount / day____. # of years:* ___________