**ELLERSLIE CHIROPRACTIC AND WELLNESS CENTRE**

**Consultation Admittance Form**

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| --- | --- | --- |
| Last Name: (Mr. Mrs. Miss) | First Name: | Today’s Date: |
| Address: | City, Province: | Postal Code: |
| Phone (Home): ( ) | Phone (Work): ( ) | Phone (Cell): ( ) |
| Alberta Health Care #: | Gender: M / F | Marital Status: (circle)Single Married Widowed Divorced |
| Emergency Contact Name: | Emergency Contact Phone : ( ) |
| Date of Birth: | Age: | Height: | Weight: |
| Occupation: | Who may we thank for referring you? |
| Email Address (optional)(Emails will be used strictly for the purpose of appointment reminders ): |  |

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Reason(s) for appointment:

When did your condition begin? Is it getting worse?

Time of day problem occurs most: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide details as to what aggravates your condition:

What makes your condition better? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Is this a Motor Vehicle Accident (MVA)? [ ]  Yes [ ]  No *If yes, please be sure to advice reception*

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

List all previous surgeries, illnesses, and injuries:

Have you had previous chiropractic care? [ ]  Yes [ ]  No Dr. Date: \_\_\_\_\_\_\_

What were you treated for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

1. Heart or blood diseases Yes No
2. Bone spurs on the neck bones (cervical sprain) Yes No
3. Whiplash injury (flexion-extension injury, cervical sprain) Yes No
4. Have you or any of your relatives ever suffered a stroke? Yes No
5. Were you ever a smoker? Yes No

 From to

1. Do you take medication on a regular basis? Yes No
2. Visual disturbances (blurring, loss, double vision) Yes No
3. Hearing disturbances (loss, ringing, other noise) Yes No
4. Slurred speech or other speech problems Yes No
5. Difficulty swallowing Yes No
6. Dizziness Yes No
7. Loss of consciousness, even momentary blackouts Yes No
8. 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

1. 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** |
| FeverSweatsFaintingSleep disturbanceFatigueNervousnessWeight lossWeight gain | Chronic coughSpitting up phlegmSpitting up bloodChest painWheezingDifficulty breathingAsthma | Frequent urinationPainful urinationBlood in urinePus in urineKidney infectionProstate troubleUncontrollable urine flow |
| **NEUROLOGICAL** | **CARDIOVASCULAR** | **GASTROINTESTINAL** |
| Visual disturbanceDizzinessFaintingConvulsionsHeadacheNumbnessNeuralgia (nerve pain)Poor coordinationWeakness | Rapid beating heartSlow beating heartHigh blood pressureLow blood pressurePain over heartHardening of arteriesSwollen anklesPoor circulationPalpitationsCold hand or feetVaricose veins | Poor appetiteDifficult digestionHeartburnUlcersNauseaVomitingConstipationDiarrheaBlood in stoolGallbladder/jaundiceColitis |
| **EYES, EARS, NOSE, THROAT** | **MUSCLE & JOINT** | **FOR WOMEN ONLY** |
| Eye painDouble visionRinging in earsDeafnessNosebleedsTrouble swallowingHoarsenessSinus infectionNasal drainageEnlarged glands | Neck painLow back painArm painShoulder painLeg painKnee painFoot painPain/numbness down arms or legsPain between shoulders swollen jointsSpinal curvatureArthritisFractures | Painful menstruationHot flashesIrregular cycleCramps or back painVaginal dischargeNipple dischargeLumps in breastMenopausal symptomsBirth control pillsMiscarriagesComplications with pregnancyPregnant? Y / N Week?Other:  |