CONSULTATION ADMITTANCE FORM

Last Name: _____ First Name:_____

Address:_____ City_____

Postal Code:_____ Home Phone:_____ Work Phone:_____

Age: _____ Birth date (dd/mm/yr):_____Sex: M / F Height_____ Weight_____

Occupation:_____ Alberta Health Care #:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason 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? What tests and when? _____

_____

Is this condition related to: Work? □ Yes □ No Has your employer been notified? □ Yes □ No

Motor vehicle accident? □ Yes □ No Date of injury: _____

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

Can you perform your daily work activities? □ All activities □ Only some □ Not at all

Describe your stress level: □ None □ mild □ Moderate □ High

Do you exercise? □ Daily □ Occasionally □ Not at all

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____

_____

_____

Have you had previous chiropractic care? □ Yes □ No Doctor: _____ Date: _____

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

_____

Date: _____ Patient Signature: _____

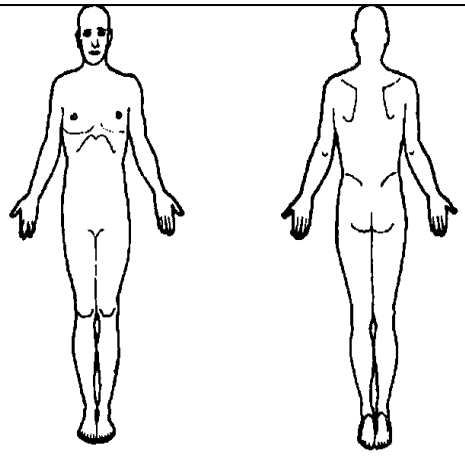
HEALTH HISTORY QUESTIONNAIRE

Name:_____

Have you ever been diagnosed or told you have any of the following?
Please 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, Where?	Yes	No
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? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)	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, 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



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……***

Please ***circle*** any conditions that are ***presently*** causing you a problem and **underline** those that have caused you problems in the **past.**

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