OKOTOKS CHIROPRACTIC & MASSAGE

PATIENT ADMITTANCE FORM

The information collected from this form is required for our professionals to provide you with the highest level of comprehensive care. The information that you provide is strictly confidential and for office use only. Thank you in advance for your cooperation!

Personal Information

Name: _____ Alberta Health Care Number: _____
Last First

Address: _____
Apt/Unit Street City/Province Postal Code

Date of Birth: _____ Age: _____ Marital Status: S ☐ M ☐ C/L ☐ W ☐ D ☐
dd/mm/yyyy

Telephone: ( ) _____ Telephone: ( ) _____
Home Work/Cell

Occupation: _____ Email: _____

Emergency Contact: _____ Phone Number: ( ) _____

Personal Physician: _____ Phone Number: ( ) _____

Who referred you to the office? _____

Health History

Is this a work related injury? ☐ Yes ☐ No If yes, has your employer been notified? ☐ Yes ☐ No

Is this the result of a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No Date of Accident: _____
dd/mm/yyyy

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? _____

Can you perform activities of daily living (ADL's)? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All ☐ Some ☐ None

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date: _____

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

_____

_____

Do you have or have you been diagnosed with cancer?
Yes ☐ No ☐

Is there a family history of cancer?
Yes ☐ No ☐

Do you/have you experienced 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 ☐

Do you have headaches?
Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe ☐ Frequency: Daily ☐ Weekly ☐ Monthly ☐

Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Do you have any conditions or health concerns that we need to know about?

_____

_____

Patient Name: _____

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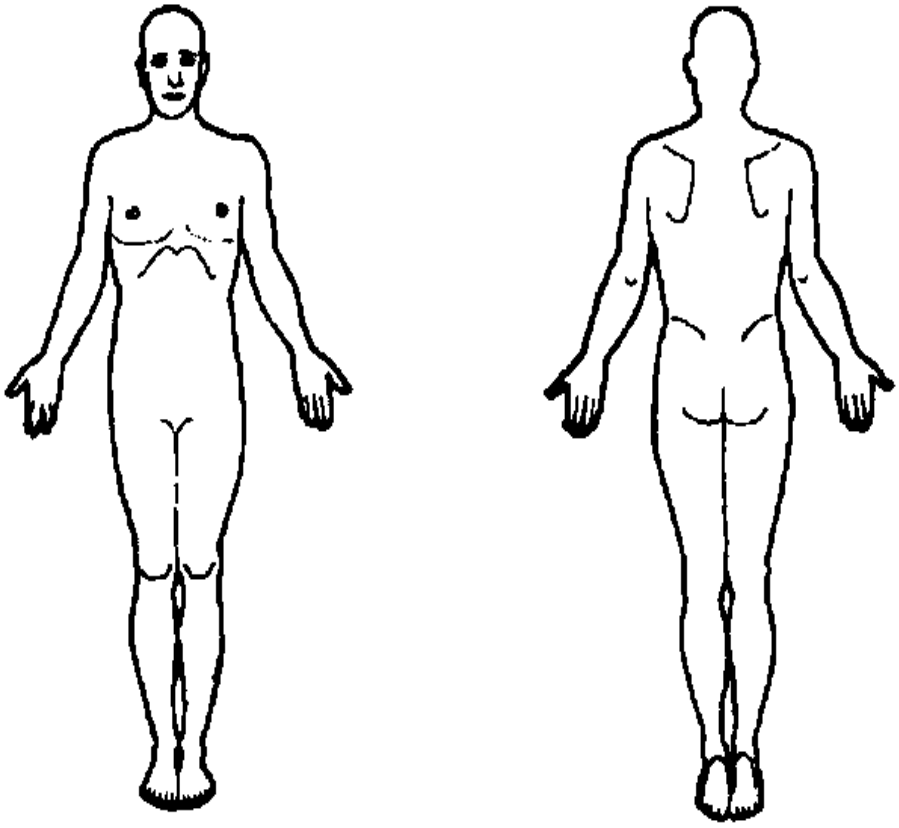
Systems Review

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

40B Elizabeth Street Okotoks, AB Phone: 403-938-2065 Fax: 403-938-6111 email: okochiro@telus.net

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

I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment.

Date: _____ Patient signature: _____

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