



**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: _____

When was your last massage therapy appointment? Therapist: _____ 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

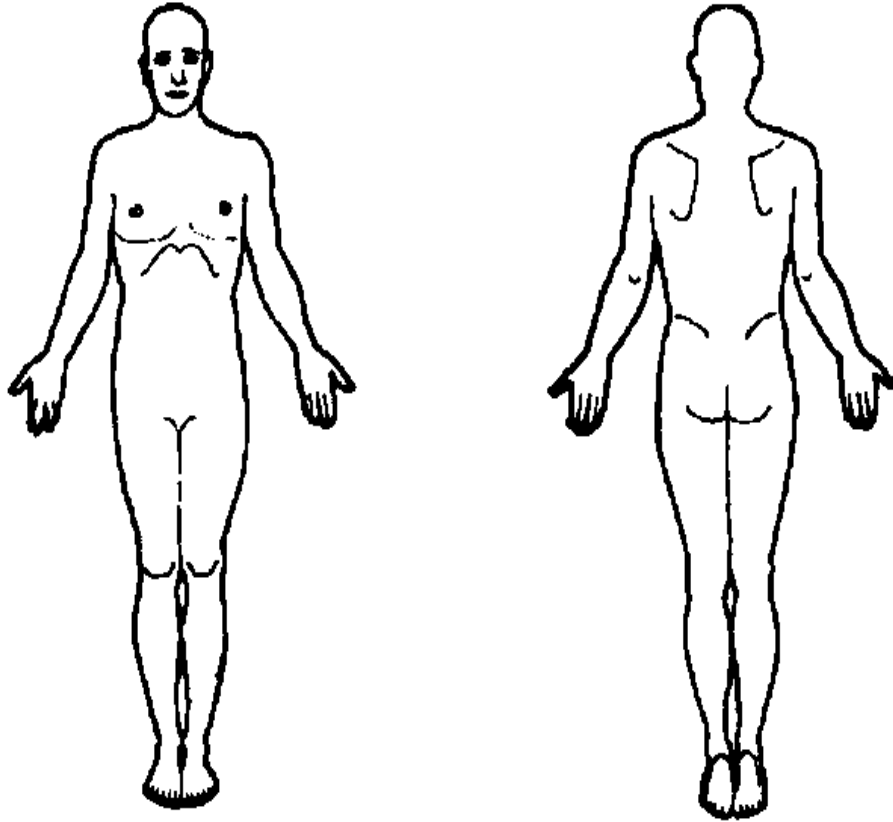
Systems Review

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 Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain Anxiety/Depression	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma Allergies COPD	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection/Disease Prostate trouble Uncontrollable urine flow STD/STI
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness Stroke	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 Rheumatic fever	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	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:

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: _____