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 care.
The information that you provide is strictly confidential and for office use only. Thank you for your cooperation!

Name: _____ Alberta Health Care Number: _____
Last First

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

Date of Birth: _____ Age: _____ Relationship Status: S ☐ M ☐ Partner ☐ W ☐ D ☐
dd/mm/yyyy

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Occupation: _____ Email: _____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail for appointment reminders and information regarding your wellness.
Do you consent? □ YES □ NO Please sign name here: _____ Date: _____

Emergency Contact: _____ Phone Number: ( ) _____

Personal Physician: _____ Phone Number: ( ) _____

How did you find us? Website ☐ Facebook ☐ Sign ☐ Referred By _____

H E A L T H H I S T O R Y

Reason(s) for appointment:

When did your condition begin?

Have you ever had similar problems? Y ☐ N ☐ When _____

Treatments tried: Dietary ☐ Supplements ☐ Chiro ☐ Massage ☐
Acupuncture ☐ Prescriptions ☐ Other ☐ _____

Have you had X-rays, MRI, or other tests for this condition? Y ☐ N ☐
Which ones?
When?

Outcome:

Conditions you are currently being treated for:

Is this a work related injury? Y ☐ N ☐

If yes, has your employer been notified?
Y ☐ N ☐ WCB? Y ☐ N ☐

Is this the result of a Motor Vehicle Accident (MVA)? Y ☐ N ☐

Date of Accident: _____
dd/mm/yyyy

Can you perform activities of daily living?
Y ☐ With Help ☐ N ☐

Can you perform daily work activities?
Y ☐ With Help ☐ N ☐

Have you been to a Chiropractor before?
Y ☐ N ☐ NAME_____

Have you had a massage before?
Y ☐ N ☐ NAME_____

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

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

Do you consider yourself: underweight ☐ overweight ☐ just right ☐?

Has your weight unintentionally changed recently? Lost ____ gained____

Would you like to gain or lose weight? _____

What are your dietary restrictions or eating plan?

Are you concerned about anything?

Do you have or have you been diagnosed with cancer?
Y ☐ N ☐
Is there a family history of cancer?
Y ☐ N ☐

Does your job expose you to harmful chemicals, radiation or life-threatening activities? Y ☐ N ☐
Which?
_____

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? Y ☐ N ☐
Do you have: Corrective lenses ☐
Hearing aids ☐
Medical device/prosthetics/implants ☐
_____

Have you had antibiotics in the last 5 yrs?
Y ☐ N ☐

Rate the following where
0 is rarely 1 is occasionally 2 is frequently 3 is often or daily

					If 2 or 3, pls describe
Stress	0	1	2	3	
Exercise	0	1	2	3	
Alcohol	0	1	2	3	
Caffeine	0	1	2	3	
Tobacco	0	1	2	3	
Recreational Drugs	0	1	2	3	
Difficulty falling asleep	0	1	2	3	
Difficulty staying asleep	0	1	2	3	
Fatigue	0	1	2	3	
Headaches	0	1	2	3	
Chronic Pain	0	1	2	3	
Loss of Appetite	0	1	2	3	
Skip breakfast	0	1	2	3	
Graze	0	1	2	3	

I would like to:

- ☐ Have more energy
- ☐ Improve my mood _____
- ☐ Be more muscular
- ☐ Get unstuck
- ☐ Improve memory
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get sick less often
- ☐ Have healthier hair, nails or skin
- ☐ Increase sex drive
- ☐ Reduce medication
- ☐ Think more clearly & be more focused
- ☐ Improve allergies
- ☐ Make a courageous change
- ☐ Other _____

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*.

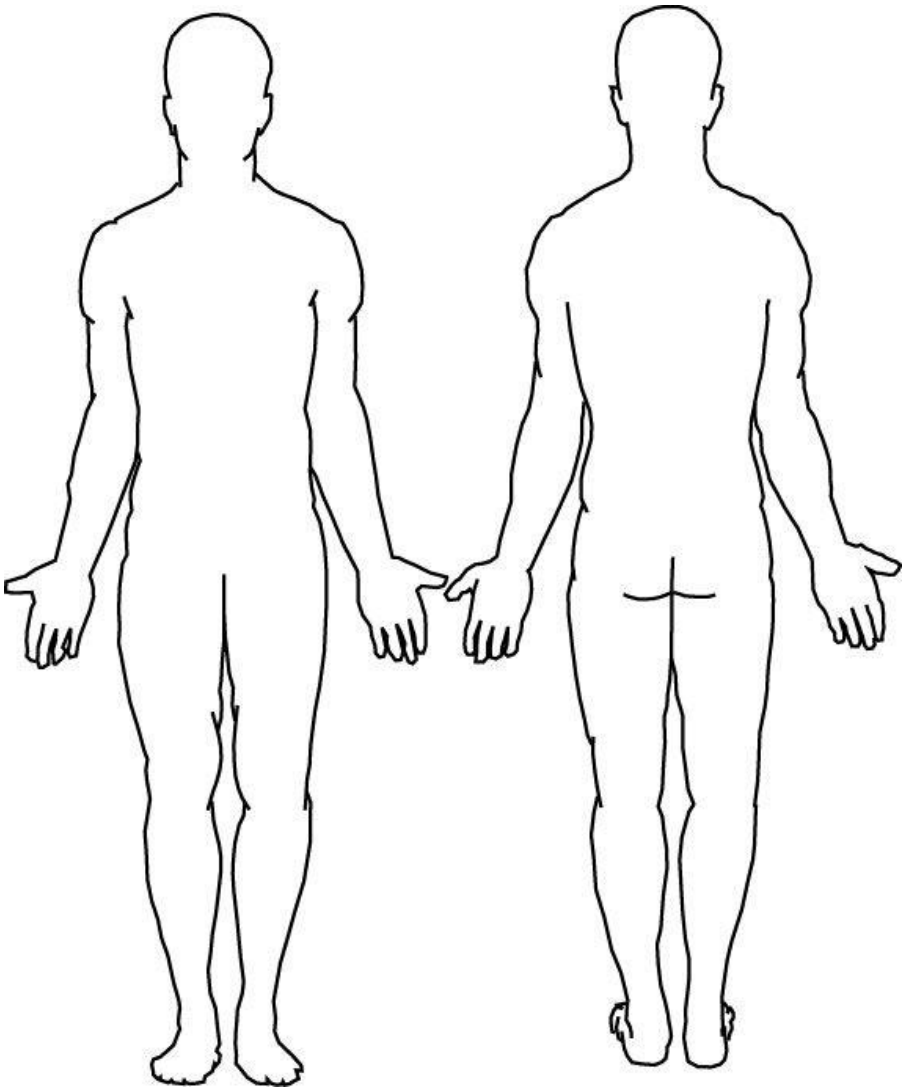
GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection/Disease
Nervousness	Difficulty breathing	Uncontrollable urine flow
Weight loss	Asthma	STD/STI
Weight gain	Allergies	
Anxiety/Depression	COPD	**Men**: Prostate trouble
Irritability		

NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Gas/bloating
Convulsions	Low blood pressure	Heartburn/Reflux
Headaches	Pain over heart	Ulcers
Numbness	Hardening of arteries	Nausea
Neuralgia (nerve pain)	Swollen ankles	Vomiting
Poor coordination	Poor circulation	Constipation
Weakness	Palpitations	Diarrhea
Stroke	Cold hands or feet	Blood in stool
	Varicose veins	Gallbladder
	Rheumatic fever	Jaundice
		Inflamed bowel

EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	WOMEN
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 in arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders	Birth control pills
Enlarged glands	Swollen joints	Miscarriages
	Spinal curvature	C-section
	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@shaw.ca

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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