

PATIENT ENTRANCE FORM



Name: _____ Date: _____
(Title) (First) (Middle Initial) (Last)

Address: _____ Postal Code: _____

Phone (H): _____ Phone (C): _____ Phone (Work): _____

Email: _____ Date of Birth: _____ M F Age: _____

Marital Status: _____ Children: _____

Occupation (Your): _____ Employer: _____

Employer Phone: _____ Address: _____

Extended Health Care Company: _____ Policy# _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our Office? _____

CLAIM WILL BE MADE AGAINST:

- 1. Recent Motor Vehicle Accident Yes No (if Yes, see attached)
- 2. Work Related Injury/Accident (WSIB claim) Yes No (if Yes, see attached)

PRIOR CHIROPRACTIC CARE:

Have you ever been to a Chiropractor before? Yes No

Chiropractor Name: _____ Clinic: _____

Date of Last Visit: _____ X-rays taken: Yes No What areas of Body? _____

Were you satisfied with your care? _____ Reason for Visit: _____

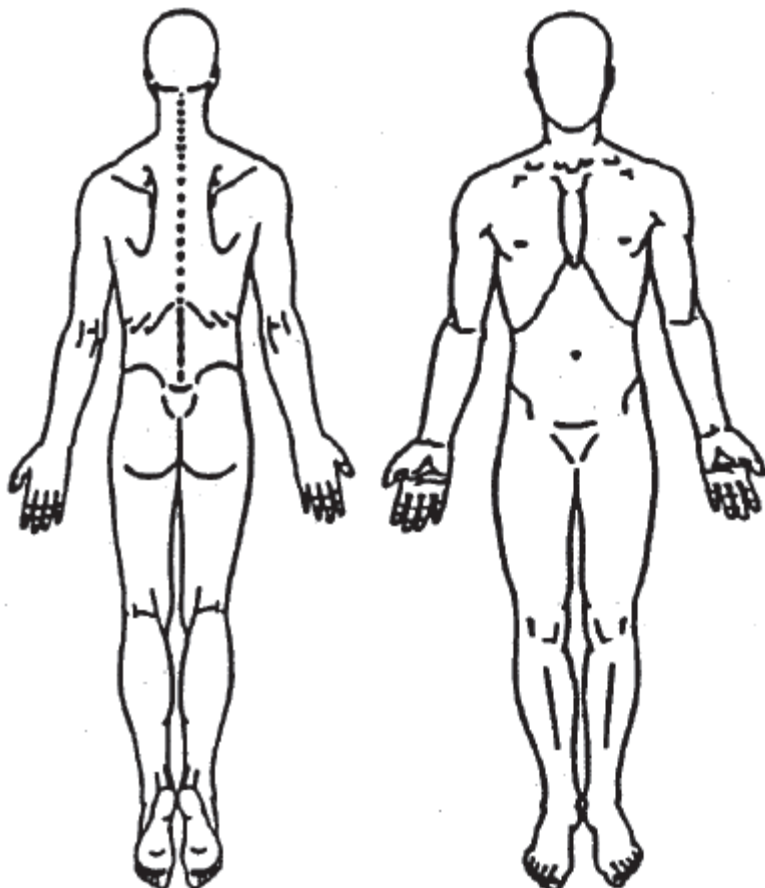
MEDICAL DOCTOR:

Name: _____ Phone: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Reason for Visit: _____

Description of current injury/pain: Primary reason for coming to clinic (detailed description)



Characteristics of the pain/complaint

Using the key below, please mark the areas of your body where you feel the described sensations. Use the appropriate symbols to show areas of pain or unusual feeling.

- XXX** = Sharp Pain/Stabbing
- TTT** = Tense/Tight
- BBB** = Burning
- AAA** = Aching/Dull
- +++** = Pins & Needles
- ////** = Numbness
- OOO** = Other (describe)

Please circle the appropriate intensity of your pain from 0-10 below:

No Pain 0----1----2----3----4----5----6----7----8----9----10 Severe Pain

Is this due to an accident? Yes No Auto Work Home Sports Other Date: _____

What treatments have you had for this problem? _____

Chiropractic Physical Therapy Massage Medical Treatment Acupuncture Other

Have you had any diagnostic studies: X-ray MRI CT scan Lab Work Other: _____

Are you currently under a doctor's care for this condition or any other condition? Yes No

What condition(s)? _____

What Doctor(s)? _____

Have you ever had any of the following: aneurysm arthritis epilepsy
heart conditions pneumonia polio cancer strokes

PATIENT PAST HISTORY

Illnesses: Have you had any significant illnesses as an : Infant Child Teen Adult
Yes No (list) _____

Do you currently have an illness? _____

Medications: List any drugs or medications you are currently taking.

Injuries: Have you ever had any significant injuries. (Detailed description and date).

Falls or Accidents – List: _____

Surgeries and Operations – List: _____

Fractures or Dislocations – List: _____

Have you ever lost consciousness, or experienced a concussion: Yes No _____

Have you ever been hospitalized: Yes No _____

Any family health conditions or problems Yes No

Please list: _____

Habits of Lifestyle:

Do you smoke: Yes No Do you have more than 2 alcoholic drinks a day Yes No

Do you exercise: Yes No How many times a week: _____

In what sports or recreational activities: _____

How many hours a night do you sleep: 4-6 6-8 8-10 Do you get enough restful sleep Yes No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

How many meals a day: 1 meal 2 meals 3 meals 4 meals > 4 meals

How would you rate your current level of stress: low moderate high extreme

Do you suffer from any other health conditions? _____

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have previously had. C-Currently P=Previously

C P

- Diabetes
- Blackouts/fainting
- Convulsions
- Chills
- Nervousness
- Dizziness
- Loss of sleep
- Fever
- Sweats
- Tremors
- Loss of balance/coordination
- Numbness in hand/arm
- Numbness in leg/foot
- Facial numbness
- Numbness other regions
- Depression
- Fatigue
- Anxiety
- Allergies
- Recent weight gain
- Recent weight loss

C P Gastrointestinal

- Poor appetite
- Loss of weight
- Indigestion
- Nausea
- Vomiting
- Vomit blood
- Diarrhea
- Constipation
- Jaundice
- Stomach pain
- Liver trouble
- Gall bladder trouble
- Colon trouble
- Excessive hunger
- Ulcer
- Hemorrhoids
- Unusual bowel patterns

C P Muscle/Joint

- Osteoporosis
- Headaches
 - hormonal
 - migraines
 - tension/stress/posture
 - cervicogenic
 - weather related
 - other
- Bursitis
- Foot trouble
- Swollen joints
- Hernia
- Low back pain
- Mid back pain
- Neck pain
- Neck stiffness
- Joint pain
- Childhood growing pains
- Weakness

C P Respiratory

- Asthma
- Chest pain
- Chronic cough
- Difficulty breathing
- Wheezing
- Spitting blood

C P Cardiovascular

- Rapid heart beats
- Slow heart beats
- Swelling of ankles
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation

C P Skin

- Itching
- Sking rashes
- Varicose veins
- Lumps
- Bruises easily
- Abnormal hair growth/loss

C P EENT

- Earache
- Hearing loss
- Loss of balance
- Ringing in ear
- Ear discharge
- Eye pain
- Blurred/double vision
- Wear glasses/contacts
- Visual problems
- Loss of smell
- Sinus infections
- Nose bleeds
- Enlarged glands
- Enlarged thyroid
- Sore throat
- Tonsillitis
- Difficulty swallowing

C P Genito-Urinary

- Painful urination
- Difficulty urinating
- Changes in frequency/colour
- Blood in urine
- Prostate problems
- Venereal disease/discharge
- Kidney trouble/infection
- Bedwetting

C P Women Only

- Menstrual irregularities
- Menstrual pain/cramps
- Breast soreness

Pregnant Yes No

Due Date: _____

Menopausal Yes No

Last menstrual date: _____

C P Other

- Mental health conditions
- HIV/AIDS/Hepatitis
- Diseases/illnesses

Please check the phrase that most represents your reasons for care!

- Symptom Relief:** i.e. Get rid of the pain!
- Corrective/Functional Care:** i.e. Get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems, ex. Weak muscles, chronic spinal dysfunction, poor posture, chronic tightness. etc.
- Performance/Wellness Care:** i.e. I acknowledge that there are many causes of daily repeated physical stress to my body – keep me performing my best – at home, at work, at sport, and or at play.

What are your expectations – What would you like to achieve by coming to our clinic?

Our primary goal is to always work towards the resolution of your condition, as quickly as possible. Help us achieve your goal by listing your expectations!

Before we begin treatment, do you have any questions or concerns that you would like us to address about the therapy? This can include chiropractic manipulation, previous experiences, office policies, health questions? We believe that good patient communication is essential and we always want to understand your perspective – both positive and negative!

Is there a particular technique you would prefer us to use in the treatment of your case?

Our clinician will use the most appropriate techniques for the resolution of your health!

- I would like the doctor to decide which technique is the most appropriate for my condition**
- Chiropractic manipulation/mobilization
- Myofascial Release Technique (MRT)
- Personal Training
- Acupuncture (Electro and Manual)
- Exercise and Rehabilitation protocols: Shoulder, Knee, Back, Neck, Whole Body (please circle)
- Core Strengthening; Stretching protocols
- Laser, Ultrasound, Electrical Therapies
- Kinesiotape

Financial Policy:

Payment is due at the time services are rendered. Patients are responsible for their accounts.

Our office does not file insurance claims for you; however we will provide you with a receipt for you to submit for reimbursement. We do require 24 hours notice for cancelled appointments. Missed appointments will be charged \$5.00, Subsequent missed appointments will be charged 50% of the regular fee to the patients account. I have read and understand Peterborough Chiropractic Group's financial policy and hereby agree to pay any and all charges at the time services are rendered.

Signature: _____ Date: _____