Consultation Admittance Form

Last Name:_____ First Name:_____ Gender M / F

Address_____ City_____ Postal_____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( )_____

Alberta Health Care #_____ Third Party Insurance _____

Emergency Contact Name: _____ Emergency Contact Phone:_____

Date of Birth: D____ M___ Y___ Age: _____ Height: _____ Weight: _____ Marital Status_____

Occupation: _____ Referred By _____

Email (used for newsletters and appointment reminders)_____

Please check all answers and fill in the blanks where appropriate.

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?_____

_____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a motor vehicle accident (MVA)? ☐ Yes ☐ No On what date did the accident occur_____

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

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

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

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

What kind of exercise do you do?_____

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

_____

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

Family doctor name Dr._____

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

_____

_____

Reason you are taking medication:_____

Date:_____ Patient Signature_____