CR8WELLNESS
FOR FAMILY CHIROPRACTIC

PATIENT ENTRANCE FORM

Name ______________________________________ Date ____________________

Address ____

City, Province _________________________________ Postal Code _______________

Home Tel. ___________________________ Business Tel. _______________________

Email Address ____

Date of Birth (D/M/Y) _______________________ Age ______ Marital Status S M D W S

Preferred Pronouns (optional): ___________ Current Gender: ______________________

Spouse's Name ____________________________ Children _____________________

Occupation (Your) ____

Employer ____

Address ____

City ____ Phone ___________________

Closest Relative _________________________________ Phone __________________

Extended Health Care Company ____

Policy # __________________________________

How did you hear about our office: ☐ friend ☐ social media ☐ Google ☐ other: _________

PRIOR CHIROPRACTIC CARE:

Name: ___________________________________ Telephone: ___________________

X- Rays taken: ☐ Yes ☐ No Date: ___________________

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name: ___________________________________ Telephone: ___________________

Address: ____

Date of Last Appointment __________________ Date of Last Physical ________________

Reason for consulting this office:

____

____

____

____

Expectations:

____

Show area(s) of pain or unusual feeling:

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation. Include all the affected areas.

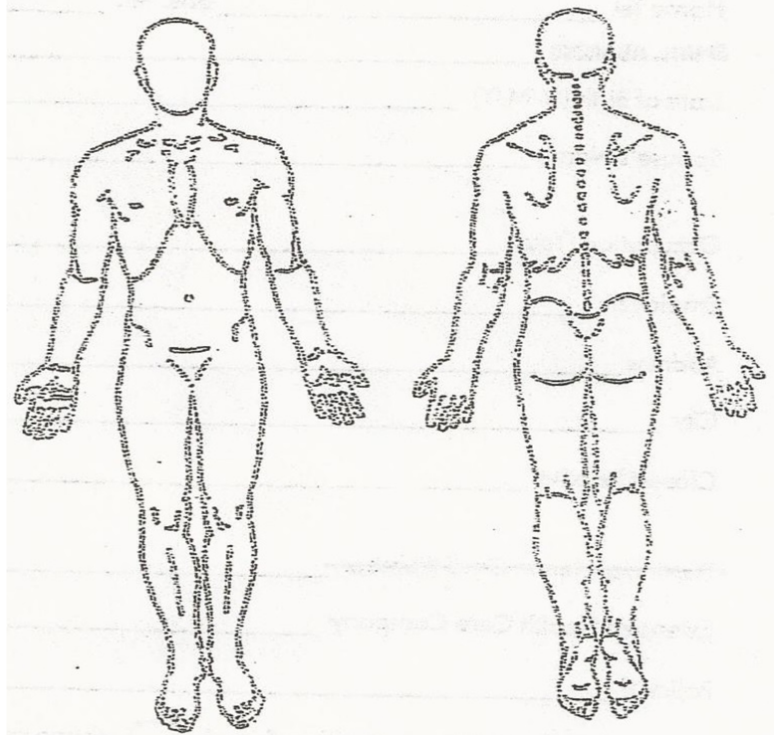
Numbness: ○○

Pins & Needles: 0 0

Burning: X X

Aching: ✡ ✡

Stabbing: / /



Childhood conditions had, please check:

☐ measles	☐ mumps	☐ chicken pox
☐ scarlet fever	☐ diphtheria	☐ rheumatic fever
☐ ear infections	☐ tubes in ears	☐ chronic ill
☐ typhoid fever	☐ whooping cough	