



Energy Chiropractic Consultation Admittance Form

Last Name:		First Name:	Gender: M / F	
Address:		City, Province:	Postal Code:	
Phone (Home) ()		Phone (Work) ()	Phone (Cell) ()	
Alberta Health Care #			Third Party Insurance #	
Emergency Contact Name:			Emergency Contact Phone ()	
Date of Birth: d/m/y	Age:	Height:	Weight:	
Occupation:		Marital Status: Single Married Widowed Divorced		
May we contact you by email? (appointment reminders only) <input type="checkbox"/> Yes <input type="checkbox"/> No email address _____				

How did you find out about our clinic? If recommended, please state name. _____

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 Not at all

Describe your stress level None Mild Moderate High

Do you exercise? Daily Occasionally Not at all

What kinds 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.: _____

Date: _____ Patient signature: _____

Parent/Guardian (if applicable) _____

Health History Questionnaire

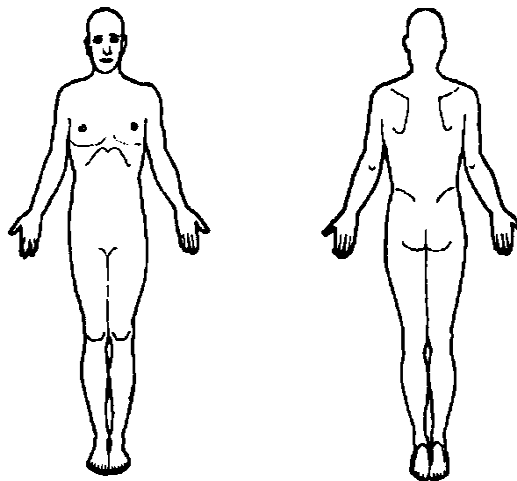
Patient name _____

Date _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ----- Yes No
2. Hardening of the arteries (arteriosclerosis)----- Yes No
3. Diabetes----- Yes No
4. Tuberculosis----- Yes No
5. Cancer ----- Yes No
Where? _____
6. Heart or blood diseases ----- Yes No
7. Bone spurs on the neck bones (cervical sprain)----- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) ----- Yes No
9. Have you or any of your relatives ever suffered a stroke? ----- Yes No
10. Were you ever a smoker? ----- Yes No
From _____ to _____
11. Do you take medication on a regular basis? ----- Yes No
12. Visual disturbances (blurring, loss, double vision)----- Yes No
13. Hearing disturbances (loss, ringing, other noise) ----- Yes No
14. Slurred speech or other speech problems ----- Yes No
15. Difficulty swallowing ----- Yes No
16. Dizziness ----- Yes No
17. Loss of consciousness, even momentary blackouts ----- Yes No
18. 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
19. Sudden collapse without loss of consciousness----- Yes No

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

Systems Review

Patient Name: _____ Date: _____

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	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	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	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: