Chiropractic Patient Admittance Form

PERSONAL INFORMATION

Last Name:_______________________________ Given Name:_______________________ Initial:_____

Address:____

City/Province:____ Postal Code:______________________

Home Phone:___________________ Work Phone:____________________ Cell:____________________

E-mail Address:____

Date of Birth (D/MM/YYYY):____ Male □ Female □

Emergency Contact Person:______________________________ Their Phone #:___________________________

Married □ Single □ Widowed □ Separated □ Common-Law □ Number of Children:______________

Occupation:_______________________________________ Employer:________________________________

Do you have extended health care benefits? No □ Yes □ With Whom?___________________________

Policy / Plan #:______________________________ Group / ID #:________________________________

We appreciate those who refer their friends, family and colleagues to our office. Please let us know who referred you to us!

Name:______________________________ Relationship to you:_____________________________

If you weren't referred, how did you hear about us?____

CURRENT HEALTH CONCERNS

Purpose of this appointment:____

Other Doctor's seen for **this** condition/Date you saw them:____________________________________

When did this condition begin?____

If disabled from work, please give dates:____

Job Related □ Auto-related □ Other □ Please explain:______________________________________

What do you hope to gain from your treatment here? *Check all that apply*
Pain reduction □ Return to function □ Future prevention □ Comprehensive care □
If you are interested in comprehensive care, please check the boxes that interest you:
Vitamins/minerals/supplements □ Information on nutrition □ Orthotics □ Sports performance □

Have you been to a Chiropractor before? Yes □ No□ If so, who and when?_____________________

Name of Medical Doctor and last date of visit:____

Please list any prescription and non-prescription medications, vitamins and supplements that you take and the reason for using them:____

____

____

Please list any serious illnesses, surgeries, auto injuries, hospitalizations or broken bones:____

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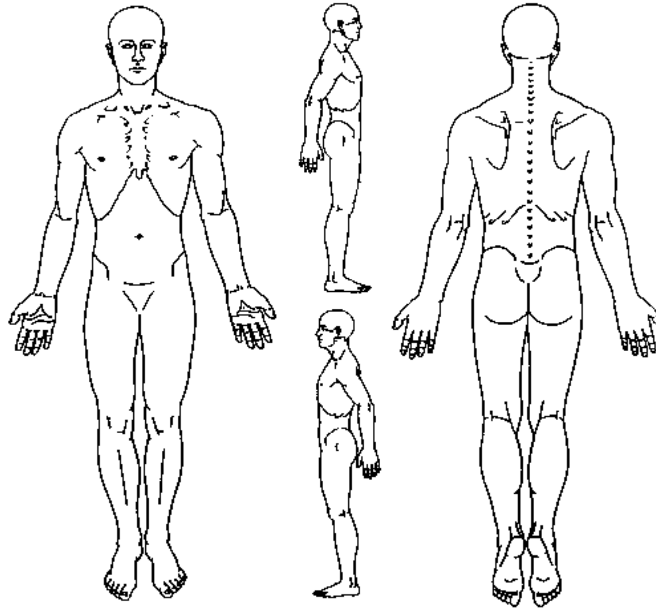
____

On the diagrams below, please circle the area(s) that apply most to where you experience and/or feel the pain/discomfort:



REVIEW OF SYSTEMS

Please check the box if you are currently experiencing any of these symptoms

Mental/Emotional: □ Mood swings □ Anxiety/nervousness □ Poor Concentration
□ Memory Problems □ Depression □ Anger

Endocrine: □ Thyroid Disease □ Heat/Cold intolerance □ Diabetes □ Sugar Sensitivities
□ Fatigue □ Weight loss/Weight gain

Immune: □ Chronic Infections □ Chronic swollen glands □ Slow wound healing
□ Frequent colds

Skin: □ Rashes □ Eczema, Hives □ Acne, Boils □ Itching

Head: □ Headaches □ Migraines □ Head injury

Ears: □ Earaches □ Impaired hearing □ Dizziness □ Ringing in Ears

Nose & sinuses: □ Nosebleeds □ Seasonal Hay fever □ Sinus problems □ Loss of smell

Mouth & Throat: □ Frequent sore throat □ Sore tongue/lips □ Tonsils removed □ Change or loss of taste

Respiratory: □ Cough □ Wheezing □ Asthma □ Bronchitis □ Emphysema
□ Chronic Phlegm □ Pneumonia

Cardiovascular: □ Heart disease □ High/low blood pressure □ Palpitations □ Arrhythmia
□ High cholesterol □ Cold extremities

Gastrointestinal: □ Heartburn □ Belching/passing gas □ Change in thirst □ Change in appetite
□ Constipation □ Diarrhea
How many bowel movements do you have per day?________________ Per week?_________________
Have you ever had parasites? □ Yes □ No □ Don't know
Have you ever had a colonoscopy? □ Yes □ No

Genitourinary: □ Difficulty with urination and/or frequent urination □ Frequent night-time urination
□ Incontinence □ Discharge or sores □ Chronic infections

Nervous system: □ Numbness/pain in extremities □ Tingling in hands/feet □ Paralysis

Musculoskeletal: □ Pain/swelling/stiffness in joints □ Muscle aches/cramp □ Recurrent back/neck pain □ Pain spreading into the arms and/or legs

WOMEN'S HEALTH

Is there a chance you could be pregnant? □ Yes □ No

Number of previous pregnancies?_______________ Number of miscarriages/abortions?____________

Have you ever used birth control? □ Yes □ No What type?_________________ How long?_________

How long between your periods?_____________

Do you experience: □ Heavy flow □ Light flow □ Clotting □ Bleeding between periods □ Cramping
□ Pain during intercourse □ Low sex drive

Do you have pre-menstrual symptoms(PMS)? □ Yes □ No
Have your periods stopped(menopause)? □ Yes □ No
Date of last bone density test_____________ □ Normal □ Osteopenia □ Osteoporosis
Date of last pap test________________ □ Normal □ Abnormal
Do you perform monthly breast self-exams? □ Yes □ No
When was your last professional breast exam?____________________
Do you have regular mammograms? □ Yes □ No

MEN'S HEALTH

Do you have any of the following?

□ Hernia □ Testicular mass or pain □ Discharge or sores □ Impotence or erectile dysfunction □ Low sex drive □ Prostate condition
Do you perform testicular self-exams? □ Yes □ No
Date of last prostate exam?__________________________

Informed Consent for Acupuncture Care FORM -AC
Please Read Carefully before signing

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed. I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

I intend this consent to apply to all my present and future acupuncture care.
Dated this_____________ day of_________________________, 20______.

Patient Signature (Legal Guardian) **Witness of Signature**
Name:__________________________ Name:______________________________