CONSULTATION ADMITTANCE FORM

Last Name: _____ First Name:_____

Address:_____ City_____

Postal Code:_____ Home Phone:_____ Work Phone:_____

Age: _____ Birth date (dd/mm/yr):_____Sex: M / F Height_____ Weight_____

Occupation:_____ Alberta Health Care #:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason 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? What tests and when? _____

_____

Is this condition related to: Work? □ Yes □ No Has your employer been notified? □ Yes □ No

Motor vehicle accident? □ Yes □ No Date of injury: _____

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

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

Describe your stress level: □ None □ mild □ Moderate □ High

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

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____

_____

_____

Have you had previous chiropractic care? □ Yes □ No Doctor: _____ Date: _____

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

_____

Date: _____ Patient Signature: _____