CrowWest Chiropractic & Massage 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.) _____

_____

I understand that Alberta Health Care coverage for chiropractic care represents only a portion of the Doctor's recognized fee schedule and that I am personally responsible for the balance of that fee.

Date: _____ Patient Signature: _____

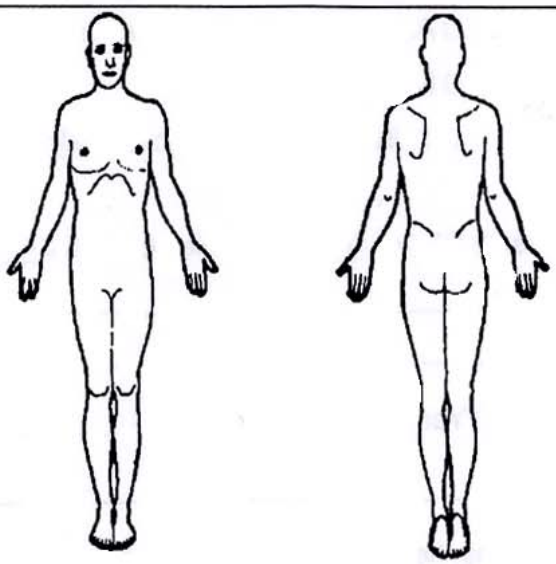
HEALTH HISTORY QUESTIONNAIRE

Name:_____

Have you ever been diagnosed or told you have any of the following?
Please 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, Where?	Yes	No
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? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)	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, 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



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