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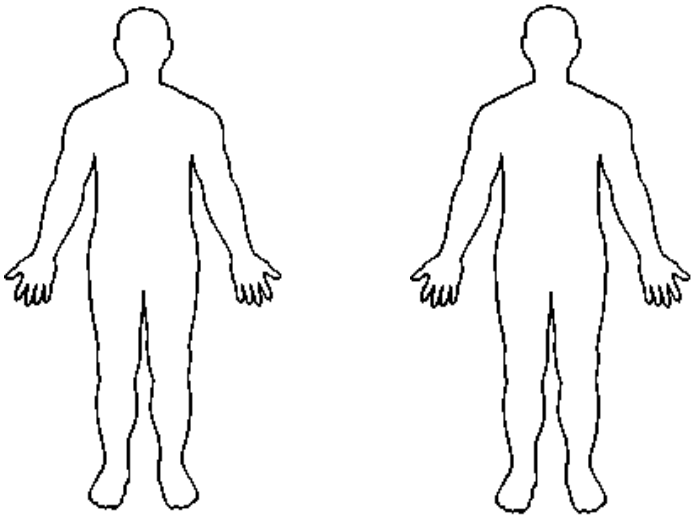
Patient Entrance Form

Patient Number: _____
Name: _____ Date: _____
Mailing Address: _____ Postal Code: _____
Home phone: _____ Daytime phone: _____
Date of Birth/Age: _____ Marital Status: S M D W S Sex: M F
Occupation/Employer: _____
Medical Doctor: _____ Referred By: _____
Previous Chiropractor: _____
E-mail: _____ May we leave message or mailing? Yes No

Explain your current complaint: _____
_____
_____
_____
List other Health Concerns: _____
List Medications / Dose: _____
List Hospitalizations / Surgeries / Traumas: _____
_____

Kindly complete the Symptom Diagram below using the following symbols:

Numbness	??????
Burning	//////////
Pins & Needles	.....
Sharp & Stabbing	XXXX
Dull & Achy	+++++
Stiff & Tight	222222
Weakness	wwww



Front *Back*

Pain Scale: place an X to correspond with your level of discomfort:

Day	0	10
Night	0	10
Sitting	0	10
Standing	0	10
Walking	0	10
Working	0	10
Sleeping	0	10

PLEASE COMPLETE THE SECOND SIDE:

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Symptoms: Past and Present

Please **circle** any condition or symptom that you are **presently experiencing**.
Please **check off** those conditions or symptoms that you have **experienced in the past**.

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headaches
Fever
Sweats
Fainting/ dizziness
Clumsiness
Slurred speech
Convulsions
Loss of sleep
Night pains
Nervousness/ anxiety
Paralysis
Numbness, pain, or tingling
Loss/ increase of weight

MUSCLES AND JOINTS
Neck pain
Mid-back pain
Low back pain
Painful tail bone
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Ankle pain
Foot pain
Weakness/ loss of strength
Arthritis
Degenerative disc disease
Tendonitis/ bursitis
Jaw/ TMJ pain
Cortisone injections
Gout

E.E.N.T.
Eye pain
Doublet blurred vision
Seeing black spots/ stars
Failing vision
Earache
Deafness/ gradual hearing loss
Ringing/ buzzing in ears
Frequent colds
Sinus infection
Asthma
Enlarged glands/ nodes
Enlarged thyroid
Difficulty swallowing

RESPIRATORY
Chronic cough
Spitting up phlegm or blood
Chest pain
Difficulty breathing
Shortness of breath

CARDIOVASCULAR
Stroke
Heart attack
High/ low blood pressure
Pacemaker
Angina
Bleeding disorder
Varicose veins
Swelling of ankles/ legs
Poor circulation
High cholesterol
Congestive heart failure

GASTROINTESTINAL
Poor appetite
Belching/ gas
Heartburn
Ulcers
Nausea/ vomiting (blood?)
Pain over stomach
Excessive hunger
Gall bladder problems
Liver problems
Jaundice/ yellow skin colour
Constipation
Diarrhea
Hemorrhoids

GENITOURINARY
Painful/ excessive urination
Trouble initiating urination
Abnormal urine colour/smell
Kidney problems/ infections
Prostate problems
Bladder problems/ infections
Hernia
Pain in genitals
Lumps in genitals

SKIN
Rashes/ itching/ dryness
Hives
Bruise easily
Infections
Changes in area/ border/ colour/ size of moles

FOR WOMEN
Painful menstruation
Irregular cycle
Excessive flow
Cramps
Hot flashes
Menopause
Swollen breasts
Lump(s) in breasts
Endometriosis
Abnormal vaginal discharge

Have you ever taken oral contraceptives?
Yes / No
Are you currently taking oral contraceptives?
Yes / No
Is there a chance you may be pregnant?
Yes / No
pregnancies ____
children ____

GENERAL HISTORY
Have you had any fractures?
Yes / No
Have you ever had surgery or been hospitalized?
Yes / No
Have you ever been in a motor vehicle accident or had other major trauma?
Yes / No
Have you smoked tobacco in the past?
Yes / No
packs/ day/ years _____
Do you currently smoke?
Yes / No
Do you take medication on a regular basis?
Yes / No
Do you suffer from allergies?
Yes / No

*****Please indicate if you have been diagnosed with any of the following:*****

Cancer, Diabetes, Hepatitis A/B/C, Tuberculosis, HIV/AIDS.

Please notify the doctor if you have been diagnosed with a major systemic illness/disease

Patient name:_____ **Date:**_____ **File #:**_____