Chiropractic Patient Entrance Form

Name_____Date_____

Address_____ City_____PostalCode_____

Phone: Res._____ Bus._____ Cell._____

Date of Birth (D/M/Y)_____Age_____ Email address_____

Referred by_____ M.D. Name and Address _____

_____

May we communicate with your other health care providers concerning your health? Yes / No.

Occupation_____Employer_____

Have you ever received Chiropractic Care? Yes / No Results: excellent good fair poor

Addressing the Issues that brought you to Healing Hands

Those who are already experiencing Chiropractic Wellness and are here to continue need only circle here **"Wish to continue My Chiropractic Wellness Experience".** Others should briefly **describe the chief area of complaint**, including the effect it has had on your life. _____

_____

Describe your pain:

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Problem started_____☐ It's getting worse ☐ It's work related

What makes it worse_____ or better_____

Is it worse during certain times of the day?_____

It interferes with ☐ work ☐ sleep ☐walking ☐ sitting ☐ other _____

Other health care providers seen for this problem _____

Goals for your chiropractic care: _____

Please check all symptoms you have even if they do not seem related to your current problem.

☐ Headaches/migraines	☐ Pins & needles in legs	☐ Fainting	☐ Stomach upset
☐ Neck pain/stiffness	☐ Pins & needles in arms	☐ Ears ring/buzz	☐ Heartburn
☐ Sleeping problems	☐ Numbness in fingers	☐ Fever	☐ Ulcers
☐ Back pain	☐ Numbness in toes	☐ Loss of smell	☐ Cold sweats
☐ Nervousness	☐ Shortness of breath	☐ Loss of taste	☐ Loss of balance
☐ Tension	☐ Fatigue	☐ Diarrhea	☐ Problem urinating
☐ Irritability	☐ Depression	☐ Constipation	☐ Menstrual irregularity
☐ Chest pains	☐ Light bothers eyes	☐ Feet cold	☐ Menstrual pain
☐ Dizziness	☐ Loss of memory	☐ Hands cold	

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Stroke
Father's side:	☐	☐	☐	☐	☐
Mother's side:	☐	☐	☐	☐	☐

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Your Birth Process	**Yes**	**No**	**Comments**
Was the delivery long?	☐	☐	
Was the delivery difficult?	☐	☐	
Forceps?	☐	☐	
Caesarean?	☐	☐	
Breach?	☐	☐	
Home birth?	☐	☐	
Hospital birth?	☐	☐	
Mother given drugs during delivery?	☐	☐	
Was labour induced?	☐	☐	
Your Childhood Years			
Did you have any childhood illnesses?	☐	☐	
While learning to walk, did you fall?	☐	☐	
Did you play youth sports?	☐	☐	
Did you take or use any drugs?	☐	☐	
Did you have any surgery?	☐	☐	
Have you fallen/jumped from height over 3 feet? (ie. Crib, bed, trees, stairs)	☐	☐	
Were you involved in any car accidents as a child?	☐	☐	
Did you suffer any other traumas?	☐	☐	
Was there any prolonged use of medicine? (ie. antibiotics, inhalers)	☐	☐	
As a child, were you under regular chiropractic care?	☐	☐	
Adult (15 to present)	**Yes**	**No**	**Comments**
Did / do you smoke?	☐	☐	
Did / do you drink alcohol?	☐	☐	
Do you exercise?	☐	☐	
What activities?			How often?
Have you been in any car accidents?	☐	☐	
Have you had any work-related injuries?	☐	☐	
Have you had sports-related injuries?	☐	☐	
Did you have any surgery?	☐	☐	
Did / do you take any drugs? (Prescriptive / non-prescriptive)	☐	☐	
Rate your diet	poor / fair / med / good/ excellent		
Sleeping posture (please circle)	side / stomach / back		
On a scale of 1 to 10, describe your stress level?	Home___ Work ___		
How often do you eat (meals/day)			

By signing below, I acknowledge that the information given is true and that all fees billed on my behalf, including to third party payors, are my obligation to pay.

Signature:_____Date:_____

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