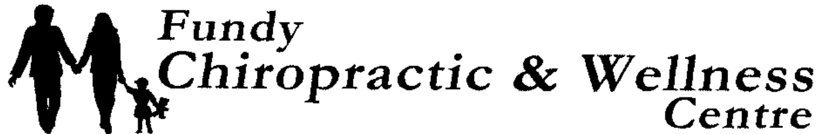

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PATIENT ENTRANCE FORM

Name ____________________________________ Date of Birth (Day/Month/Year) _______________

Street ____________________________________ Age ______ Sex: Male ____ Female ____

Town & Prov______________________________ Occupation _______________________________

Postal Code ______________________________ Employer _________________________________

Email ____________________________________ Employer's Address _______________________

I consent to receiving email from Fundy Chiropractic and Wellness Centre ____

Home # __________________________________ Marital Status ____________________________

Work # ___________________________________ Name of Spouse/Partner ____________________

Cell # ____________________________________ Number of Children _________________________

Name of Alternate Contact and Phone #____

How did you hear about this office? ____

Health Insurance: Company ____

Policy/Plan # ___________________________ ID # ___________________ Primary Cardholder? ________

If no, name of Primary Cardholder __________________________Relationship:(ie. Spouse, child)___________

Claim will be made against:

Recent motor vehicle accident Yes No (if yes, please notify receptionist)
Work related accident/injury Yes No (if yes, please notify receptionist)

Reason for consulting this office:

Presenting complaint (what hurts) ____

____

Expectations ____

Prior Chiropractic Care:

Name of Chiropractor _______________________ Telephone _________________________________
Reason for visit: this complaint? Yes _ No_
If no, please state the complaint ____

Results: Excellent Good Fair Poor

Medical Doctor:

Name of family physician ____________________ Telephone ______________________________

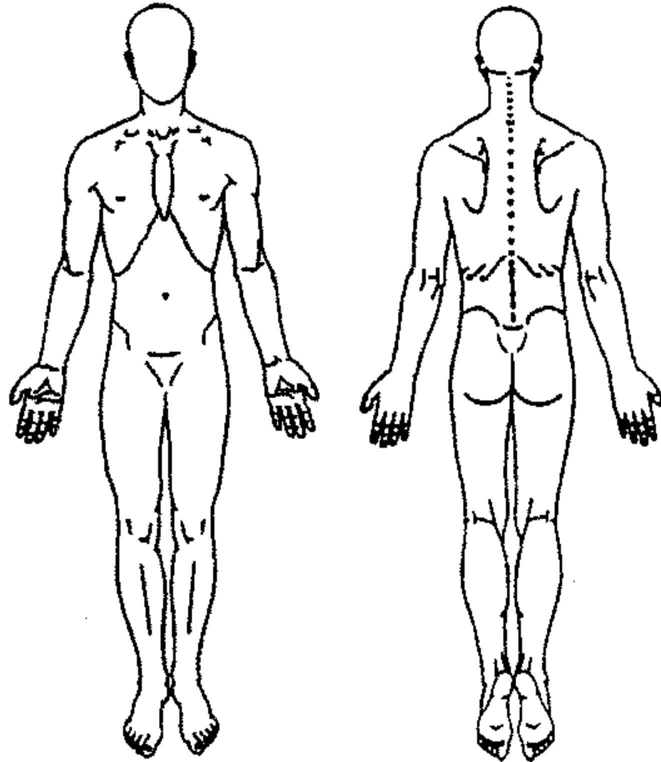
Have you seen your M.D. regarding today's complaint? Yes No

Date of last appointment _____________________ Date of last physical ______________________

X-rays taken? Yes No Date ___________________________________

Draw In Your Face

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.



PAIN	Circle area
NUMBNESS	^^^^^^^^^^
PINS & NEEDLES	000000000
BURNING	xxxxxxxxxx
ACHING	* * * * *
STABBING	/ / / / / / /
TIGHTNESS	#########

Have you ever had any of the following?

- ❑ aneurysm
- ❑ osteoporosis
- ❑ diabetes
- ❑ arthritis
- ❑ respiratory conditions
- ❑ epilepsy
- ❑ cancer
- ❑ stroke(s)
- ❑ allergies
- ❑ heart conditions
- ❑ hepatitis
- ❑ nervousness
- ❑ anxiety
- ❑ fatigue
- ❑ polio
- ❑ sleeping difficulty
- ❑ pneumonia
- ❑ pleurisy
- ❑ asthma
- ❑ V.D.
- ❑ psoriasis
- ❑ HIV
- ❑ sinus condition

Please check any childhood conditions

- ❑ measles
- ❑ scarlet fever
- ❑ ear infections
- ❑ mumps
- ❑ diphtheria
- ❑ tubes in ears
- ❑ chicken pox
- ❑ rheumatic fever
- ❑ chronic illness
- ❑ whooping cough
- ❑ typhoid fever

Habits of Lifestyle

Do you smoke? Yes No

If so, how much? ______________

Do you exercise Yes No

Do you consume alcohol? Yes No

If so, how much? ______________________________

Exercise – indoor activities ________________________

Exercise – outdoor activities _______________________

Rate your sleep hours per night 4-6 6-8 8-10 12+

Do you wake rested? Yes No

Rate your appetite	poor	fair	medium	good	excellent
Rate your diet	poor	fair	medium	good	excellent
Do you eat regularly?	Breakfast	Lunch	Dinner		
Do you eat per day?	1 meal	2 meals	3 meals	4 meals	5+ meals

Date of last dental examination ____________________

List any falls or accidents (including childhood) ____

____

List any surgery or operations ____

List any surgery suggested but not performed ____

Have you ever been knocked unconscious? Yes No Don't Know

If so, for how long?____

Do you take vitamins or minerals? Yes No List: __________________________________

List any medications or drugs you are currently taking and the reason for each: _________________

____

____

Have you previously been hospitalized? Yes No

If so, why were you hospitalized? ____

Any family health conditions or problems? Yes No

Please list: ____

____

____

Signature ______________________________ Date ______________________________________