

PARALLEL CHIROPRACTIC & WELLNESS CENTRE

Chiropractic Patient Entrance Form

Patient Name: _____ **Date:** _____
Home Address: _____ **City:** _____ **Postal Code:** _____
Phone #: _____ **Work #:** _____ **Cell #:** _____
Date of Birth: (Month)____(Day)____(Year)____ **Female**___ **Male**___ **AHC #**_____
Occupation:_____ **Who recommended you to our clinic?** _____
Email:_____ **I consent to receive emails for appointment reminders** _____(Initial)
Marital Status: S___M___W___D___C/L___ **Emergency Contact:**_____#_____
Medical Doctor: _____ **Phone:** _____
Have you had previous Chiropractic care: Y___N___ **When?** _____ **Where?** _____
Is this a WCB related injury? _____ **MVA?** _____ **If so When?** _____

Health History – Please check symptoms you have or have had in the past year:

<p style="text-align: center;"><u>General</u></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness/Faint <input type="checkbox"/> Headaches <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Sleep Deprivation <input type="checkbox"/> Weight Loss <input type="checkbox"/> Arthritis <input type="checkbox"/> Allergies <p style="text-align: center;"><u>Muscle/Joint/Bone</u> Having pain, weakness, or numbness in:</p> <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Upper Back <input type="checkbox"/> Middle Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Knees/Ankles <input type="checkbox"/> Feet/Toes <input type="checkbox"/> Arms/Wrists <input type="checkbox"/> Hands/Fingers <input type="checkbox"/> Jaw	<p style="text-align: center;"><u>Cardiovascular</u></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke (TIA) <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Rapid/Slow Heart Rate <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Do you smoke? <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Inhaling Completely <p style="text-align: center;"><u>Gastrointestinal</u></p> <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Stomach Pain Other _____ _____	<p style="text-align: center;"><u>Genito-Urinary</u></p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urination <p style="text-align: center;"><u>Eye, Ear, Nose, Throat</u></p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Double vision <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Vision – Flashes/Halo <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Headaches <input type="checkbox"/> Tension <input type="checkbox"/> Migraines Other _____ _____	<p style="text-align: center;"><u>Men Only</u></p> <input type="checkbox"/> Erectile Difficulties <input type="checkbox"/> Other <p style="text-align: center;"><u>Women Only</u></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Other Date of mammogram: _____ Are you pregnant? _____ Number of children _____ <p style="text-align: center;"><u>Skin</u></p> <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <p style="text-align: center;"><u>General</u></p> Date of last Physical: _____ Other _____
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Please list any medications you are taking _____

Please list any illnesses or surgeries and their dates _____

Please list any accidents and their dates _____

REASON FOR CONSULTING THIS CLINIC:

- 1)___ I have a specific problem and require help only with this problem.
- 2)___ I am interested in strategies to insure the problem does not return.
- 3)___ I am interested in strategies to improve my overall health.

What is your major complaint? _____

How long have you had this condition? _____

How did this condition occur? _____

Have you had a similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition interfering with your 1)Work?_____ 2)Sleep?_____ 3)Daily Routine?_____

How long has it been since you really felt good? _____

On a scale of 1 – 10 describe your stress level (1=none / 10=severe)

Occupational _____ Personal _____

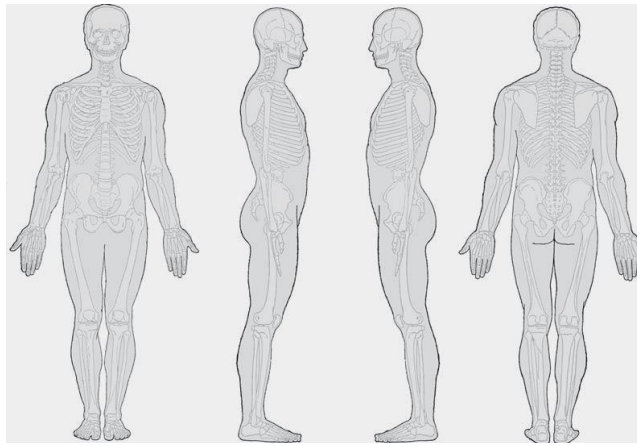
On a scale of *Poor, Fair, Good, and Excellent*, describe your: Diet___ Exercise___ Sleep___ General Health___

Using an 'X', mark on the line below where you would best describe your pain level today

No Pain [____.____.____.____.____.____.____.____.____.____.] **Worst Pain**

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS.
USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS.

PAIN AREA(S)	ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
	////////	+++++++	oooooooo	bbbbbbb	sssssss



PROFESSIONAL FEE SCHEDULE

Initial Visit: - Case history, all examinations and computer spinal analysis \$95 Subsequent visits: - \$48

Re-evaluations: includes adjustment & spinal analysis - \$78

Active Release Technique: - \$48, With adjustment \$78

Senior/Student visits: -Initial visit - \$78, Subsequent visits - \$43, Re-evaluation - \$68

Please be advised there is a 24-hour cancellation policy in effect; any appointment not cancelled within 24hours will be billed full appointment price

I have read, understood and consent to the above mentioned fee schedule, and I declare that the above information is correct and that I have not withheld any medical information.

Name _____

Date _____

Signature _____

Witness _____