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: (optional)_____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:*

General
- □ Chills
- □ Depression
- □ Dizziness/Faint
- □ Headaches
- □ Fever
- □ Forgetfulness
- □ Nervousness
- □ Numbness
- □ Sweats
- □ Sleep Deprivation
- □ Weight Loss
- □ Arthritis
- □ Allergies

Muscle/Joint/Bone

Having pain, weakness, or numbness in:
- □ Neck
- □ Shoulders
- □ Upper Back
- □ Middle Back
- □ Lower Back
- □ Hips
- □ Legs
- □ Knees/Ankles
- □ Feet/Toes
- □ Arms/Wrists
- □ Hands/Fingers
- □ Jaw

Cardiovascular
- □ Diabetes
- □ Heart Disease
- □ Stroke (TIA)
- □ Chest Pain
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Irregular Heart Beat
- □ Rapid/Slow Heart Rate
- □ Poor Circulation
- □ Do you smoke?
- □ Varicose Veins
- □ Shortness of Breath
- □ Difficulty Inhaling Completely

Gastrointestinal
- □ Poor Appetite
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Excessive Thirst
- □ Gas
- □ Indigestion
- □ Nausea/Vomiting
- □ Stomach Pain

Other_____
_____

Genito-Urinary
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

Eye, Ear, Nose, Throat
- □ Blurred vision
- □ Crossed eyes
- □ Double vision
- □ Sinus Problems
- □ Asthma
- □ Hay Fever
- □ Hoarseness
- □ Persistent Cough
- □ Difficulty Swallowing
- □ Earaches
- □ Ear discharge
- □ Hearing Loss
- □ Ringing in Ears
- □ Nosebleeds
- □ Vision – Flashes/Halo
- □ Contact Lenses
- □ Headaches
  - □ Tension
  - □ Migraines

Other_____
_____

Men Only
- □ Erectile Difficulties
- □ Other

Women Only
- □ Breast lump
- □ Menstrual Problems
- □ Hot Flashes
- □ Other

Date of mammogram:
_____
Are you pregnant?
_____
Number of children_____

Skin
- □ Bruise Easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Eczema
- □ Psoriasis

General

Date of last Physical:
_____
Other_____

(OVER)

Please list any medications you are taking_____

_____

Please list any illnesses or surgeries and their dates_____

_____

Please list any accidents and their dates_____

_____

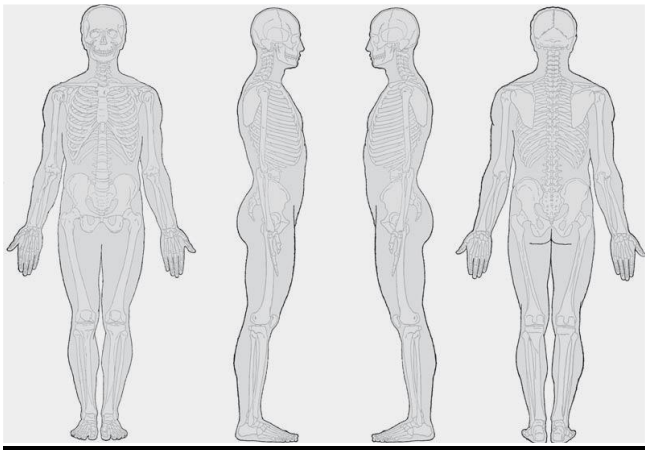
REASON FOR CONSULTING THIS CLINIC:

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 ***P**oor*, ***F**air*, ***G**ood*, and ***E**xcellent*, 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 <u>ALL</u> AFFECTED AREAS.

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



<u>PROFESSIONAL FEE SCHEDULE</u>

<u>Initial Visit:</u> - Case history and all examinations $110, *<u>Subsequent visits:</u>* - $55
<u>Re-evaluations:</u> includes adjustment & spinal analysis - $89
<u>Active Release Technique:</u> - $55, With adjustment $89
<u>Senior/Student visits:</u> -Initial visit - $100, *<u>Subsequent visits</u>* - $50, *<u>Re-evaluation</u>* - $85

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_____