McKENZIE TOWNE CHIROPRACTIC

AND MASSAGE

PATIENT ENTRANCE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (for appointment reminders and/or receipts)

Date of Birth: (DD/MM/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: single married common law divorced widowed

Prov. Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Benefit Plan? Yes No Benefit Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office: friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 website  sign Facebook other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*The clinic is aware of the sensitivity of your personal information and your personal information will not be released to any other party without appropriate authorization from you.

\*\*The clinic collects certain information for the purpose of providing diagnostic, treatment and care services, and will only collect, use and disclose your health information in accordance with the provisions of the Health Information Act.

Have you had previous chiropractic care? Yes No

Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical doctor: Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for appointment today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a similar problem? Yes No

Have you had x-rays, MRI, or other tests for this condition? Yes No

 If Yes, which tests and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a work related injury/accident: Yes No

Is this a Motor Vehicle Accident (MVA)? Yes No

 **Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please mark the areas where you have pain or unusual feeling. Use appropriate symbols:

Numbness Pins & Needles Burning Aching Stabbing

 ••••• 00000 xxxxx \*\*\*\*\* /////



Please indicate the severity of the pain by circling a number.

**0 1 2 3 4 5 6 7 8 9 10**

No PainExtreme Pain

**Health History Questionnaire**

Have you ever been diagnosed or told you have any of the following? Please circle the correct response.

1. High blood pressure……………………………………………………… Yes No
2. Hardening of the arteries (arteriosclerosis)…………………… Yes No
3. Diabetes………………………………………………………………………. Yes No
4. Tuberculosis…………………………………………………………………. Yes No
5. Cancer……………........................................................................ Yes No Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Heart or blood diseases……………………………….……………….. Yes No
7. Arthritis………………………………………………………………..………. Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) Yes No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Have you or any of your relatives ever suffered a stroke? Yes No
10. Any other accidents, injuries, fractures (What & When?) Yes No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were you ever a smoker?.................................................... Yes No
2. Please list medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check any conditions that are presently causing you a problem, as well as those that have caused you problems in the past.

GENERAL SYMPTOMS RESPIRATORY GENITOURINARY

Past Present Past Present Past Present

Fever Chronic coughing Frequent urination

Sweats Spitting up phlegm Painful urination

Sleep disturbances Spitting up blood Blood in urine

Fatigue Chest pain Kidney infection

Nervousness Wheezing Prostate trouble

Weight loss Difficulty breathing

Weight gain Asthma

NEUROLOGICAL CARDIOVASCULAR GASTROINTESTINAL

Past Present Past Present Past Present

Visual disturbance Rapid beating heart Poor appetite

Dizziness Slow beating heart Difficult digestion

Fainting High blood pressure Heartburn

Convulsions Low blood pressure Ulcers

Headache Pain over heart Nausea

Numbness Hardening of arteries Vomiting

Neuralgia (nerve pain) Swollen ankles Constipation

Poor coordination Poor circulation Diarrhea

Weakness Blood clots Blood in stool

Bruise easily Gallbladder/jaundice

Varicose veins Colitis

Aneurysm

EENT MUSCLE & JOINT FOR WOMEN ONLY

Past Present Past Present Past Present

Eye pain Neck pain Painful menstruation

Double vision/blurring Low back pain Hot flashes

Deafness Arm pain Irregular cycle

Nosebleeds Shoulder pain Cramps or back pain

Trouble swallowing Leg pain Lumps in breast

Hoarseness Knee pain Menopausal symptoms

Sinus infection Foot pain Birth control pills

 Pain/numbness down Miscarriages

 Arms or legs Pregnancy complications

 Pain between shoulders Pregnant Yes / No

 Swollen joints

 Spinal curvature/ Scoliosis