CHIROPRACTIC
PATIENT ENTRANCE FORM

Cranbrook Chiropractic & WELLNESS CENTRE

Date:_____, 20_____

Name _____ Gender: _____

Mailing Address_____

City _____ Province_____ Postal Code_____

BC Health Care #_____ Extended Medical Insurer (ex:SunLife)_____

Home Tel#:_____ Cell#:_____Email:_____

Date of Birth (M/D/Y)_____Age:_____ Height: _____(ft) Wt:_____ (lbs)

Occupation:_____Employer:_____ Bus Tel#:_____

Reminders: □Text □Email □Neither

Emergency Contact: Name_____ Relationship_____ Phone#_____

How did you hear about our office? ☐ phonebook ☐ sign ☐ internet ☐ other_____

Is this the result of a motor vehicle accident? Yes□ No□ (If Yes, ask for an MVA form)

Is this the result of a work place (WCB) injury? Yes□ No□ (If Yes, ask for an WCB form)

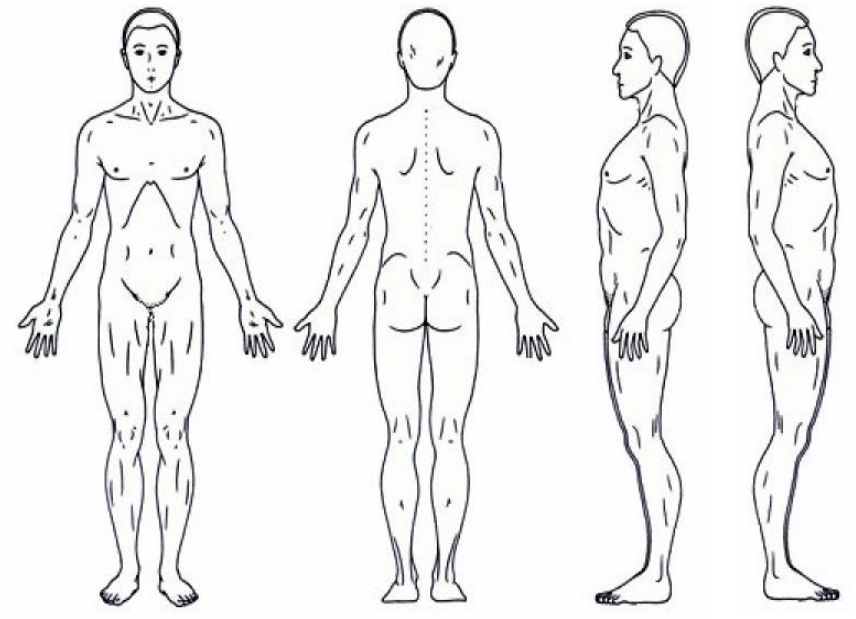
Reason for Consulting this office:_____

How long have you been experiencing this? _____

Have you felt this before? Y□ N□ When?_____ Chronic ongoing□ Chronic on/off□

What makes it **better**? _____What makes it **worse**? _____

Show the area(s) of pain or unusual feeling. Mark the areas using the legend provided.



Legend
Numbness ●●●●
Pins/Needles 0000
Burning xxxx
Aching ****
Stabbing //////

0 1 2 3 4 5 6 7 8 9 10
|_____|

No Pain **Severe Pain**

PATIENT PAST HISTORY

Have you ever had any of the following? Please check of the box where applicable.

Aneurysm	☐	Epilepsy	☐	Asthma	☐
Osteoporosis	☐	Cancer	☐	Psoriasis	☐
Diabetes	☐	Strokes	☐	Sinus Conditions	☐
Arthritis	☐	Allergies	☐	Bursitis	☐
Respiratory Conditions	☐	Heart Conditions	☐	Other _____	☐
Hepatitis	☐	Nervousness	☐	Pain Between shoulder	☐
Fatigue	☐	Polio	☐	Pain with Feet	☐
Sleeping Difficulties	☐	Pneumonia	☐	Lower Back Pain	☐
Sciatica	☐	HIV	☐	Headaches	☐
Dizziness/Vertigo	☐	Swollen Joints	☐	Neck Pain/Stiffness	☐

Please include any information you feel is pertinent on any items checked off above

_____

_____

Relevant Family History (Cancer, Heart Disease etc)_____

_____

Do you smoke? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Have you had any surgery or operations? If yes, please list _____

List any medication or drugs you are currently taking: _____

Falls and Accidents? If yes please list: _____

Have you had previous Chiropractic Care? Yes□ No□ Last Visit_____

If yes, what was the name of your previous Chiropractor?

□ Dr Mike Harach □ Dr Carl Weber □ Dr. EZ Mile Other_____

If you have been to a chiropractor previously, what were the results? Please **circle** the applicable.

Excellent Good Fair Poor Other _____

Medical Doctors Name _____

Last Appointment (roughly)? _____ Last Physical?_____

Have you ever had x-rays taken? Yes□ No□ If yes, please list areas and when taken

_____

Do you see any other health care professionals? (physio, massage, acupuncture, naturopath)?

Please List _____

I confirm the above mentioned information is correct and accurate to my knowledge. I agree a $25.00 "Missed Appointment" fee may apply if appointment is not cancelled prior to the scheduled time.

SIGNATURE_____ DATE_____