CONSULTATION ADMITTANCE FORM Date: _____

Last Name:_____ First Name:_____ Mr. Mrs. Miss. Ms. Dr.

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-Mail Address: _____

Marital Status: S M D W C Birth Date: (MM/DD/YR):_____ Gender: M / F / O

Occupation: _____ Alberta Health Care #:_____

Who should we contact in case of emergency?_____ Phone: _____

So we may Thank them, Who referred you to our clinic? _____

Is this condition related to: Work? ☐Yes ☐No If yes, Has your employer been notified? ☐Yes ☐No

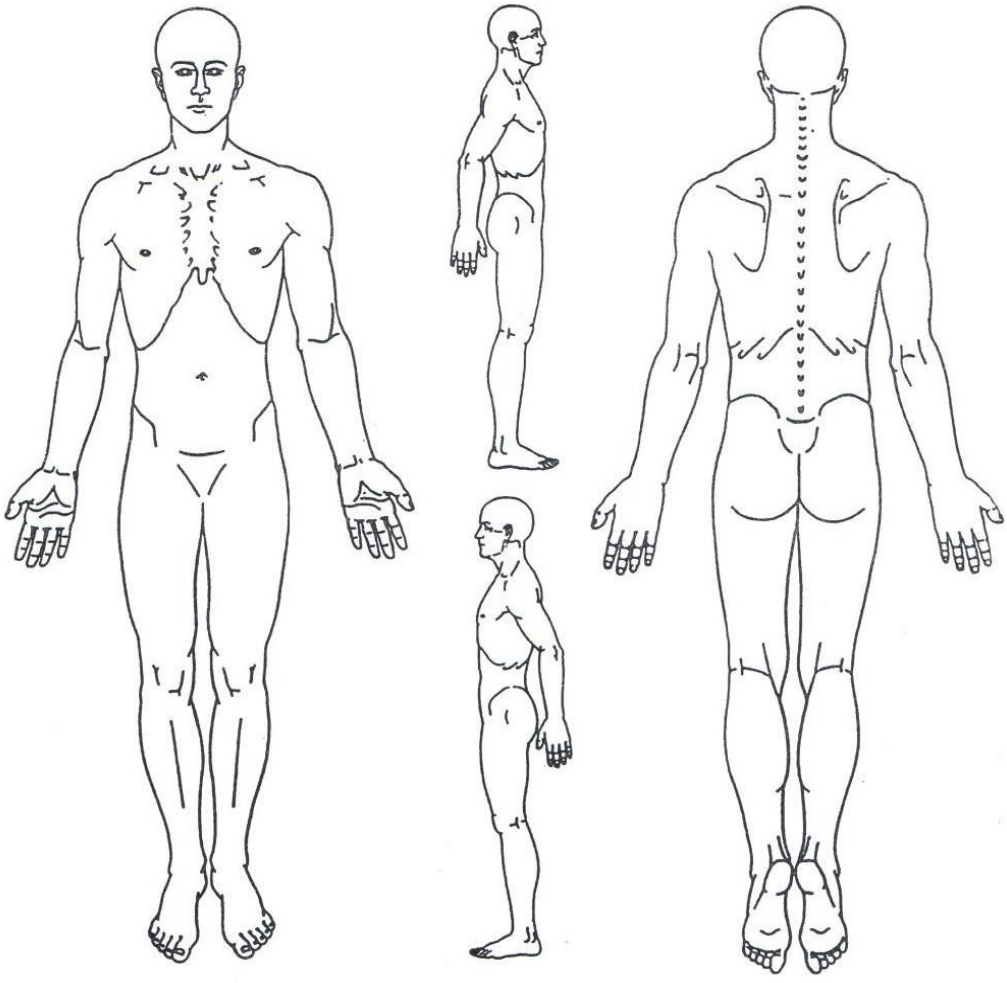
Motor vehicle accident? ☐Yes ☐No Date of accident / injury: _____

Please use the diagram below to circle/draw your areas of concern.

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS

A=ACHE **B** =BURNING **N** =NUMBNESS **P** =PINS & NEEDLES **S** =STABBING **O** =OTHER

NOTES



PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment? _____

When did your condition begin / How did symptoms occur? _____

How would you describe the pain? _____

Have you ever had similar problems? ☐Yes ☐No

Does the problem/pain refer or travel to other areas? _____

Do you have any secondary problems/symptoms? _____

When do you notice the problem the most? _____

Rate the average pain on a scale of 0 -10. 0 1 2 3 4 5 6 7 8 9 10 (please circle)

Have you had X-rays, MRI or other tests for this condition? What test and when? _____

Have you seen anyone for this condition? ☐Yes ☐No Who? _____

Can you perform your daily home activities? ☐Yes ☐Yes, only with help ☐Not at all

Can you perform your daily work activities? ☐All activities ☐Only some ☐Not at all

Describe your stress level: ☐None ☐Mild ☐Moderate ☐High

Do you exercise? ☐Daily ☐Occasionally ☐Not at all

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)

_____

_____

PAST HISTORY Have you ever had any of the following:

	Describe	**Date**
Surgeries:		
Injuries/Sports Injuries:		
Motor Vehicle Accidents:		
Hospitalizations:		
Major Illnesses/Diagnosis:		