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:____
(Optional; to be used only for e-mail reminders and practitioner/patient communications)
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:________________________
Family Doctor name: ____
How or Who were you referred to our clinic?____

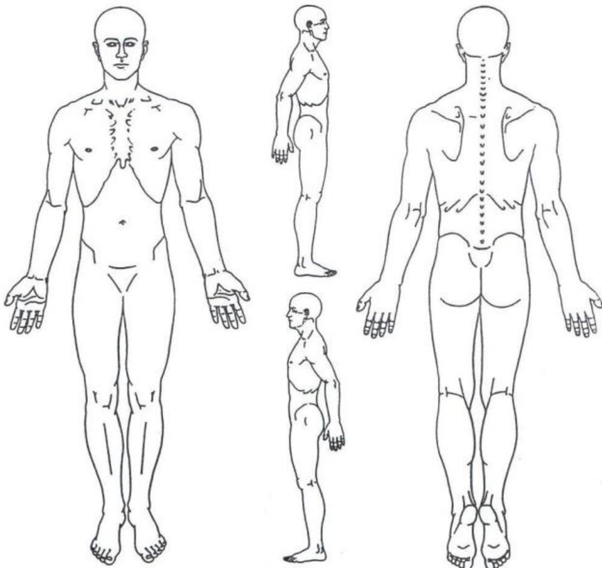
Is this condition related to: Work? ☐Y ☐N If yes, Has your employer been notified? ☐Y ☐N
Motor vehicle accident? ☐Y ☐N Date of accident / injury:______________________________________

If you are being co-managed within this clinic, do you consent to file sharing between the practitioners you are seeing within Adjust Your Health Calgary? Please initial & date:

Chiropractic __________	Date ________
Physiotherapy_________	Date ________
Acupuncture ___________	Date ________
Massage therapy ________	Date ________

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



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

Reason for appointment? ____

When and how did the condition/symptoms occur? ____
Have you ever had similar problems? ☐Yes ☐No

Are there things that make it better or worse? ____

How would you describe the pain? ____

Can you identify the main site of the problem/pain? ____

Does the symptom/pain refer or travel to other areas/locations? Where? _____________________________

When do you notice the problem the most? ____

Do you have any secondary problems/symptoms? ____

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

Have you had a diagnostic test (i.e. X-rays, MRI, CT, Ultrasound) 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?	☐Yes	☐Only some	☐Not at all	
Describe your recent level of stress:	☐None	☐Mild	☐Moderate	☐High
Do you exercise?	☐Daily	☐Occasionally	☐Not at all	

List ALL medication: (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:	