PATIENT ENTRANCE FORM

Name: _____ **Date:** _____
(Title) (First) (Middle Initial) (Last)

Address: _____ **Postal Code:** _____

Phone (H): _____ **Phone (C):** _____ **Phone (Work):** _____

Email: _____ **Date of Birth:** _____ **M □ F □ Age:** _____

Marital Status: _____ **Children:** _____

Occupation (Your): _____ **Employer:** _____

Employer Phone: _____ **Address:** _____

Provincial Health Card Number: _____ **Exp. Date:** _____

Extended Health Care Company: _____ **Policy#** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

How did you hear about our Office? _____

CLAIM WILL BE MADE AGAINST:

1. Recent Motor Vehicle Accident Yes ⊖ No ⊖ (if Yes, see attached)
2. Work Related Injury/Accident (WSIB claim) Yes □ No □ (if Yes, see attached)

PRIOR CHIROPRACTIC CARE:
Have you ever been to a Chiropractor before? Yes □ No □

Chiropractor Name: _____ **Clinic:** _____

Date of Last Visit: _____ **X-rays taken:** Yes □ No □ What areas of Body? _____

Were you satisfied with your care? _____ **Reason for Visit:** _____

MEDICAL DOCTOR:

Name: _____ **Phone:** _____
Date of Last Appointment: _____ **Date of Last Physical:** _____
Reason for Visit: _____

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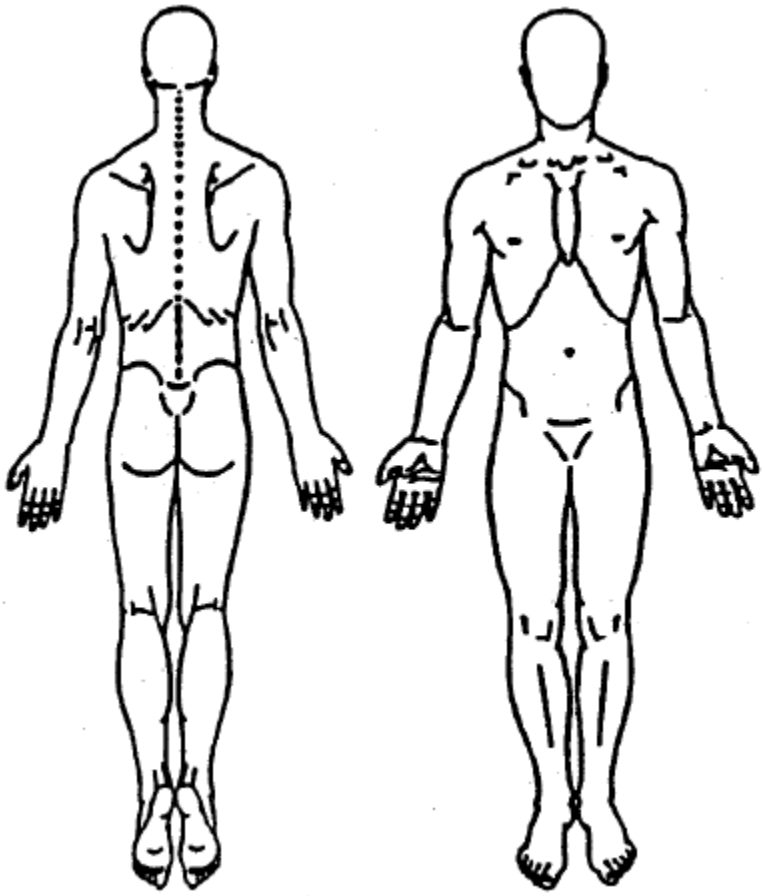
Phone: 705-874-3220

Description of Current Injury/Pain: Primary Reason for Coming to Clinic (Detailed Description)

_____
_____
_____
_____
_____



Characteristics of the pain/complaint

Using the key below, please mark the areas of your body where you feel the described sensations. Use the appropriate symbols to show areas of pain or unusual feeling.

XXX =	**Sharp Pain/Stabbing**
TTT =	**Tense/Tight**
BBB =	**Burning**
AAA =	**Aching/Dull**
++++ =	**Pins& Needles**
//////// =	**Numbness**
OOO =	**Other (describe)**

Please Circle the appropriate intensity of your pain from 0-10 below:
No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Severe Pain

Is this due to an accident? Yes □ No □ Auto □ Work □ Home □ Sport □ Other □ Date: _____

What treatments have you had for this problem? _____
Chiropractic □ Physical Therapy □ Massage □ Medical Treatment □ Acupuncture □ Other □
Have you had any diagnostic studies: X-ray □ MRI □ CT scan □ Lab Work □ Other: _____

Are you currently under a doctor's care for this condition or any other condition? Yes □ No □
What Condition(s)? _____
What Doctor(s)? _____

Have you ever had any of the following: aneurysm_____ arthritis_____ epilepsy _____
heart conditions _____ pneumonia _____ polio _____ cancer _____ strokes _____

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PATIENT PAST HISTORY

Illnesses: Have you had any significant illnesses as an : Infant □ Child □ Teen □ Adult □
Yes □ No □ (list)_____

_____

Do you currently have an illness? _____

Medications: List any drugs or medications you are currently taking. (Prescription or over the counter)

_____

_____

Injuries: Have you ever had any significant injuries. (Detailed description and date).

_____

_____

Falls or Accidents – List: _____

_____

Surgeries and Operations – List: _____

_____

Fractures or Dislocations – List: _____

_____

Have you ever lost consciousness: Yes □ No □ _____
Have you ever been hospitalized: Yes □ No □ _____

Any family health conditions or problems Yes □ No □
Please list: _____

Habits of Lifestyle:
Do you smoke: Yes □ No □ **Do you have more than 2 alcoholic drinks a day** Yes □ No □

Do you exercise: Yes □ No □ **How many times a week:** _____
In what sports or recreational activities: _____

How many hours a night do you sleep: 4-6 6-8 8-10 Do you get enough restful sleep Yes □ No

Rate your appettie: Poor Fair Medium Good Excellent
Rate your diet: Poor Fair Medium Good Excellent
How many meals a day: 1 meal 2 meals 3 meals 4 meals > 4 meals

How would you rate your current level of stress: low □ moderate □ high □ extreme □

Do you suffer from any other health conditions?_____

_____

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Please check the appropriate box for any of the following symptoms which you now have or have previously had. C= Currently P= Previously.

C P
- □ □ Diabetes
- □ □ Loss of consciousness
- □ □ Blackouts/fainting
- □ □ Convulsions
- □ □ Chills
- □ □ Nervousness
- □ □ Dizziness
- □ □ Headaches
- □ □ Loss of sleep
- □ □ Fever
- □ □ Sweats
- □ □ Tremors
- □ □ Loss of balance/co-ordination
- □ □ Numbness in arm/hand
- □ □ Numbness in leg/foot
- □ □ Depression
- □ □ Fatigue
- □ □ Anxiety
- □ □ Allergies
- □ □ Recent weight gain
- □ □ Recent weight loss

C P **Gastrointestinal**
- □ □ Poor appetite
- □ □ Loss of weight
- □ □ Indigestion
- □ □ Nausea
- □ □ Vomitting
- □ □ Vomit blood
- □ □ Diarrhea
- □ □ Constipation
- □ □ Jaundice
- □ □ Stomach pain
- □ □ Liver trouble
- □ □ Gall bladder trouble
- □ □ Colon trouble
- □ □ Excessive hunger
- □ □ Ulcer
- □ □ Hemorrhoids
- □ □ Unusual bowel patterns

C P Muscle/Joint
- □ □ Osteoporosis
- □ □ Arthritis
- □ □ Bursitis
- □ □ Foot trouble
- □ □ Swollen joints
- □ □ Hernia
- □ □ Low back pain
- □ □ Neck pain
- □ □ Neck stiffness
- □ □ Joint pain
- □ □ Weakness

C P **Respiratory**
- □ □ Asthma
- □ □ Chest pain
- □ □ Chronic cough
- □ □ Difficulty breathing
- □ □ Wheezing
- □ □ Spitting blood
- □ □ Throat phlegm

C P Cardiovascular
- □ □ Rapid heartbeats
- □ □ Slow heart beats
- □ □ Swelling of ankles
- □ □ High blood pressure
- □ □ Low blood pressure
- □ □ Pain over heart
- □ □ Poor circulation
- □ □ Stroke
- □ □ Heart attack
- □ □ Aneurysm

C P **Skin**
- □ □ Itching
- □ □ Skin rashes
- □ □ Varicose veins
- □ □ Lumps
- □ □ Bruises easily
- □ □ Abnormal hair growth/loss

C P EENT
- □ □ Earache
- □ □ Hearing loss
- □ □ Loss of balance
- □ □ Ringing in ear
- □ □ Ear discharge
- □ □ Eye pain
- □ □ Blurred/double vision
- □ □ Wear glasses/contacts
- □ □ Visual problems
- □ □ Lose of smell
- □ □ Sinus infections
- □ □ Nose bleeds
- □ □ Enlarged glands
- □ □ Enlarged thyroid
- □ □ Sore throat
- □ □ Tonsillitis
- □ □ Difficulty swallowing

C P Genito-Urinary
- □ □ Painful urination
- □ □ Difficulty urination
- □ □ Changes in frequency/color
- □ □ Blood in urine
- □ □ Prostate problems
- □ □ Venereal disease
- □ □ Kidney trouble/infection

C P **Women Only**
- □ □ Menstrual irregularities
- □ □ Menstrual pain/cramps
- □ □ Breast soreness

Pregnant: Yes □ No □
Due date: _____
Menopausal: Yes □ No □
Last menstruation date:_____

C P **Other**
- □ □ Mental health conditions
- □ □ HIV/AIDS/Hepatitis
- □ □ Cancer
- □ □ Diseases/Illnesses

Signature: _____ **Date:** _____

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Please Check the Phrase that Most Represents your Reasons for Care!

□ **Symptom Relief**: i.e. Get rid of the pain!
□ **Corrective/Functional Care**: i.e. Get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems, ex. Weak muscles, chronic spinal dysfunction, poor posture, chronic tightness. etc.
□ **Performance/Wellness Care**: i.e. I acknowledge that there are many causes of daily repeated physical stress to my body – keep me performing my best – at home, at work, at sport, and or at play.

What are your expectations – What would you like to achieve by coming to our clinic?
Our primary goal is to always work towards the resolution of your condition, as quickly as possible. Help us achieve your goal by listing your expectations!

_____
_____
_____

Before we begin treatment, do you have any questions or concerns that you would like us to address about the therapy? This can include chiropractic manipulation, previous experiences, office policies, health questions? We believe that good patient communication is essential and we always want to understand your perspective – both positive and negative!

_____
_____
_____
_____

Is there a particular technique you would prefer us to use in the treatment of your case?
Our clinician will use the most appropriate techniques for the resolution of your health!

□ **I would like the doctor to decide which technique is the most appropriate for my condition**
□ Chiropractic manipulation/mobilization
□ Active Release Technique (ART)
□ Functional Range Release (FRR)
□ Graston Technique
□ Acupuncture (Electro and Manual)
□ Kinesiotape
□ Exercise and Rehabilitation protocols
□ Stretching protocols

Financial Policy:

Payment is due at the time services are rendered. Patients are responsible for their accounts. Our office does not file insurance claims for you; however we will provide you with a receipt for you to submit for reimbursement. We do require 24 hours notice for cancelled appointments. Missed appointments will be charged 50% of the regular fee to the patients account. I have read and understand Lakeland Chiropractic Clinic's financial policy and hereby agree to pay any and all charges at the time services are rendered.

Signature: _____ **Date:** _____

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