Patient Entrance Form

General Information:

Name_____ PHN/Carecard #_____

Date of birth_____ Extended Health Care Plan_____

Address_____ Name of policy holder_____

City/Postal Code_____ Policy number_____

Home Phone_____ I.D. Number _____

Cell phone _____

If you would you like to receive appointment reminders please provide either:

Email address_____

Cell phone carrier_____

Will a claim be made against?

1. ICBC (recent motor vehicle accident) Yes No Claim # _____
2. Worksafe BC (work related injury) Yes No Claim # _____

Prior Chiropractic Care:

Name _____ City_____

Reason for prior care _____

X-rays taken Yes No Date_____ Date of last treatment _____

Medical Doctor:

Name _____ City_____

Date of last visit _____ Last physical exam _____

Presenting Complaint:

Reason for consulting this office _____

_____

Previous treatment for this complaint (physiotherapy, massage therapy, etc.) _____

_____

Past Health History

Have you ever had any of the following: (Please check)

Aneurism	____	Sleep difficulty	____
Osteoporosis	____	Allergies	____
Diabetes	____	Fatigue	____
Arthritis	____	Dizziness	____
Epilepsy	____	Venereal disease	____
Cancer	____	Psoriasis	____
Heart Disease	____	HIV	____
Stroke	____	Asthma	____

List any others not mentioned above: _____

_____

Have you ever been knocked unconscious? Yes No

Falls, Injuries and Accidents: (List)

_____

_____

_____

Surgery and Hospitalizations: (List)

_____

_____

_____

Present Medications: (List)

_____

_____

_____

Family health conditions/problems: (List)

_____

_____

_____

Habits of Lifestyle:

Do you smoke? Yes (light moderate heavy) No

Do you consume alcohol? Yes (light moderate heavy) No

Do you exercise? Yes (light moderate heavy) No

Level of stress? None Mild Moderate Excessive

Rate your appetite: Poor Fair Good Excellent

Rate your diet: Poor Fair Good Excellent

Do you take Vitamin/Mineral supplements? (List) _____

Signature: _____ Date: _____