Edge Chiropractic & Sport Therapy Patient Entrance Form

All of the information collected from this form will be kept confidential and assists in diagnosis and treatment so please be thorough and accurate.

NAME: _____ DATE: _____
ADDRESS: _____
CITY: _____ PROV: _____ POSTAL CODE: _____

TELEPHONE: Home: _____ E-MAIL: _____
Business: _____
Cell: _____ AHC #: _____

DATE OF BIRTH: Mon: Day: Yr: _____ AGE: _____

MARITAL STATUS: S M D W CL
SPOUSE NAME: _____ EMERGENCY CONTACT: _____
OF CHILDREN: _____ PHONE #: _____

EMPLOYMENT

OCCUPATION: _____
EMPLOYER: _____
ADDRESS: _____

INITIAL VISIT ***Are you consulting this clinic for an injury resulting from:***

A recent Motor Vehicle Accident? Yes _____ No _____
A work related injury/accident (WCB)? Yes _____ No _____

Reason for consulting this office: _____

How did you hear about our clinic?
Signage: _____ Friend/Family: _____ Name: _____
Phone Book: _____ Other: _____

MEDICAL HISTORY

MEDICAL DOCTOR: _____ Last appt: _____
PHONE: _____ Last physical: _____

FALLS/ACCIDENTS: _____

SURGERY & OPERATIONS _____

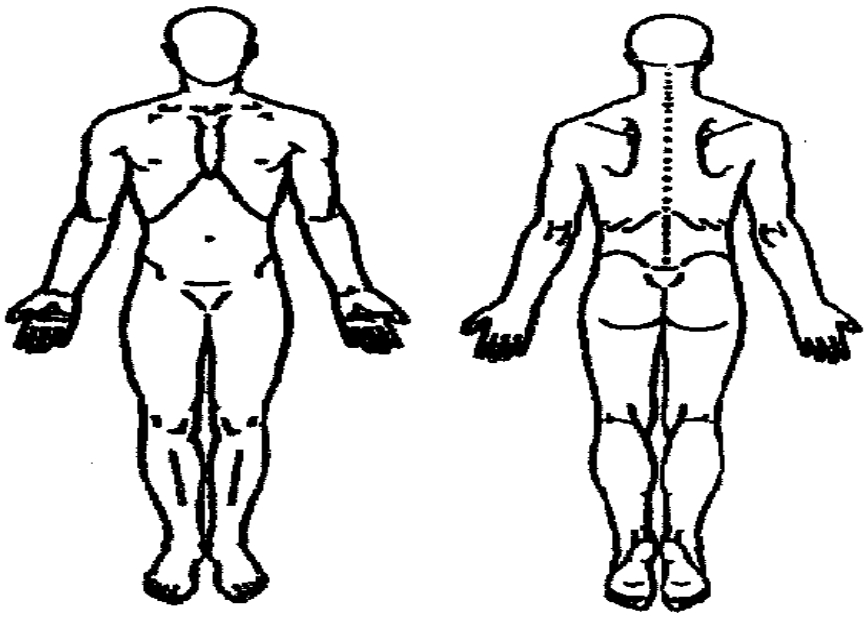
FAMILY HEALTH CONDITIONS/PROBLEMS: _____

PAIN SCALE

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | Excruciating Pain

Area(s) of Complaint

Use the diagram by circling areas of pain or unusual feeling.
Circle the appropriate description for your complaint below.
Include all affected areas.



Numbness

Pins & Needles

Burning

Aching

Stabbing

Have you ever had any of the following:

Diabetes	_____	Sciatica	_____
Cancer	_____	Swollen Joints	_____
Hepatitis	_____	Arthritis	_____
Polio	_____	Osteoporosis	_____

Cardiovascular		**Neurological**		**Gastro-intestinal**	
Rapid heart beat	_____	Dizziness	_____	Stomach pain	_____
Slow heart beat	_____	Headaches	_____	Poor appetite	_____
Swelling of ankles	_____	Loss of Sleep	_____		
Hardening of arteries	_____	Depression	_____	**Genito-Urinary**	
High Blood Pressure	_____	Neuralgia	_____	Frequent urination	_____
Low Blood Pressure	_____	Numbness	_____	Decreased bladder control	_____
Pain over heart	_____	Loss of Weight	_____	Kidney infection	_____
Poor circulation	_____	Epilepsy	_____	Painful urination	_____
Other	_____	Aneurysm	_____	Prostate trouble	_____

For Women Only		**Respiratory**	
Cramps	_____	Chest pain	_____
Low back pain	_____	Difficulty breathing	_____
Last Menstruation Date	_____		
Menopausal	_____		
Currently Pregnant	_____		

LIFESTYLE HABITS

Smoke	never	on occasion	regularly		
Exercise	never	on occasion	regularly	List Activities	_____
Take Vitamins	never	on occasion	regularly	List Vitamins	_____
Take Medications	never	on occasion	regularly	List Medications	_____
Consume Alcohol	never	on occasion	regularly		

Do you wake rested?	Yes	No		
Hours of sleep at night	4-6	6-8	8-10	10+
Rate your appetite:	Poor	Fair	Medium	Excellent