

# 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**

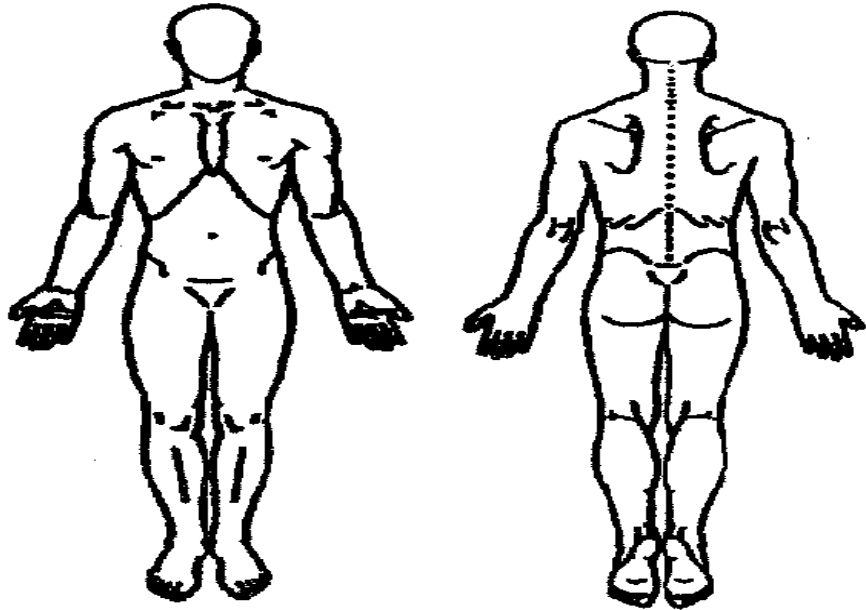
No Pain 

0	1	2	3	4	5	6	7	8	9	10
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 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 \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Hepatitis \_\_\_\_\_  
 Polio \_\_\_\_\_

Sciatica \_\_\_\_\_  
 Swollen Joints \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_

**Cardiovascular**

Rapid heart beat \_\_\_\_\_  
 Slow heart beat \_\_\_\_\_  
 Swelling of ankles \_\_\_\_\_  
 Hardening of arteries \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  
 Low Blood Pressure \_\_\_\_\_  
 Pain over heart \_\_\_\_\_  
 Poor circulation \_\_\_\_\_  
 Other \_\_\_\_\_

**Neurological**

Dizziness \_\_\_\_\_  
 Headaches \_\_\_\_\_  
 Loss of Sleep \_\_\_\_\_  
 Depression \_\_\_\_\_  
 Neuralgia \_\_\_\_\_  
 Numbness \_\_\_\_\_  
 Loss of Weight \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 Aneurysm \_\_\_\_\_

**Gastro-intestinal**

Stomach pain \_\_\_\_\_  
 Poor appetite \_\_\_\_\_

**Genito-Urinary**

Frequent urination \_\_\_\_\_  
 Decreased bladder control \_\_\_\_\_  
 Kidney infection \_\_\_\_\_  
 Painful urination \_\_\_\_\_  
 Prostate trouble \_\_\_\_\_

**For Women Only**

Cramps \_\_\_\_\_  
 Low back pain \_\_\_\_\_  
 Last Menstruation Date \_\_\_\_\_  
 Menopausal \_\_\_\_\_  
 Currently Pregnant \_\_\_\_\_

**Respiratory**

Chest pain \_\_\_\_\_  
 Difficulty breathing \_\_\_\_\_

**LIFESTYLE HABITS**

Smoke	never	on occasion	regularly
Exercise	never	on occasion	regularly
Take Vitamins	never	on occasion	regularly
Take Medications	never	on occasion	regularly
Consume Alcohol	never	on occasion	regularly

List Activities \_\_\_\_\_  
 List Vitamins \_\_\_\_\_  
 List Medications \_\_\_\_\_

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