COASTAL CHIROPRACTIC

Patient Entrance Form

DATE: _____

MSP PHN# _____

ICBC/WCB/RCMP/DVA_____

OFFICE USE ONLY
DIAGNOSIS:
ICD:

Name _____ D.O.B. _____ Age ____ Marital Status___ Sex M / F
First and Last Names Mo/Day/Yr

Address _____ City _____ Postal Code _____
Include Street type such as St., Ave., etc.

Telephone (H) _____ Cell/Pager _____ E –mail Address _____

_____
Occupation Company Name Work Phone Number

_____
Guardian/Spouse's Full Name # of children Age(s) of children

Do you have extended health care coverage? ❑ No □ Yes What company _____

How did you hear about our office? Friend/Family □ Phone book □ Sign □ Other _____

Were you referred to a particular doctor in this office and by whom? _____

Will you be filing an ICBC or WCB claim? No □ Yes □ If yes, please see receptionist for an injury report.

REASON FOR CONSULTING OFFICE _____

EXPECTATIONS _____

Personal Medical history (if any of the following are relevant to your medical history, please check accompanying box:)

❑ Aneurysm	❑ Osteoporosis	❑ Scoliosis	❑ Arthritis
❑ Epilepsy	❑ Cancer	❑ Strokes	❑ Allergies
❑ Heart condition	❑ Hepatitis	❑ Anxiety	❑ HIV/AIDS
❑ Bleeding disorder	❑ Asthma	❑ Psoriasis	❑ Tuberculosis
❑ Muscular dystrophy	❑ Multiple sclerosis	❑ Dizziness	❑ Rheumatic fever
❑ Diabetes	❑ High blood pressure	❑ Pneumonia	❑ Other _____

Have you ever had X-rays? No □ Yes □ What body part(s) and when? _____
List any surgical procedures/hospitalizations and the dates: _____
_____

List any accidents, falls or injuries and the dates: _____

_____

List any previous fractures and the dates: _____

Have you been treated by a physician for any health condition in the last year? ❑ Yes ❑ No

Describe condition _____ Date of last physical exam _____

Do you have a medical doctor? Yes □ No □ Doctor's name _____

COASTAL CHIROPRACTIC

Present State of Health

NAME: _____ **DATE:** _____

Describe your chief complaint and its location: _____

When and how did this complaint begin? _____

Has this complaint occurred before? No □ Yes □ When_____

Please circle quality of the complaint/pain: dull ache sharp burning throbbing deep nagging other ____

Does this complaint/pain radiate or travel to any areas of your body? No □ Yes □ Where _____

How frequent is the complaint present and how long does it last? _____

Does anything *aggravate* the complaint? _____

Does anything *relieve* the complaint? _____

Does this condition interfere with *(please circle one)* work sleep exercise family life other_____

Is this condition becoming? *(please circle one)* better worse staying the same

List other health care practitioner(s) seen for this condition _____

Are you currently taking medications? No □ Yes □ What _____

Are you pregnant? No □ Yes □ How many weeks _____

Do you exercise? No □ Yes □ How much _____

Do you smoke/drink/use drugs? No □ Yes □ How often _____

Do you have any other complaints _____

DOCTORS NOTES

COASTAL CHIROPRACTIC

Present State of health (Diagram)

Please grade intensity/severity of complaint/pain:

Please fill in diagram:

Show area(s) of pain or unusual feeling. Mark the areas on the diagrams where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness ● ● ● ● ●

Pins & Needles ☆ ☆ ☆ ☆ ☆

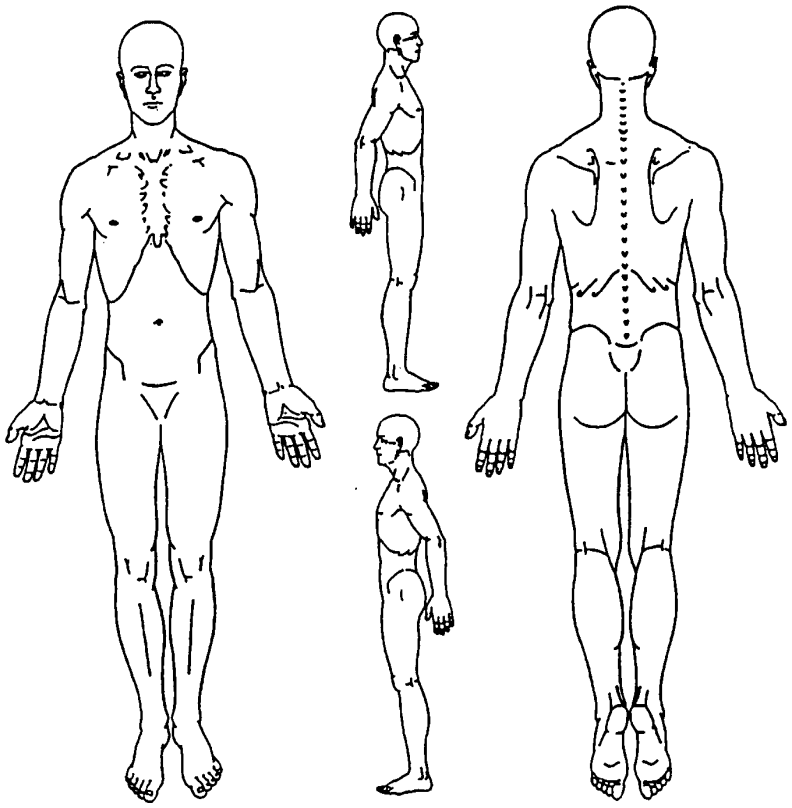
Burning △ △ △ △ △

Aching ○ ○ ○ ○ ○

Stabbing \ \ \ \ \

Stiffness *S S S S S*

Other _____ *X X X X X*



Today

(no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst complaint/pain imaginable)

On average

(no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst complaint/pain imaginable)

At its best

(no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst complaint/pain imaginable)

At its worst

(no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst complaint/pain imaginable)

DOCTORS NOTES