Consultation Admittance Form

Last Name: ______________________________ First Name: ______________________________

Address: __________________________________ City: ______________________________

Postal Code: ______________ Home Phone: ________________ Work Phone: _______________

Cell Phone: ______________ Email: ________________ _______________

Birth Date (mm/dd/yyyy): _________________________ Age: ________________ Sex: M / F

Height: ___________ Weight: ___________ Occupation: ________________________________

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment: ____

When did your condition begin: ____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had x-rays, MRIs, or other tests for this condition? Which tests and when? _______________

____

Is this condition related to: Work? ☐ Yes ☐ No

If yes, has your employer been notified? ☐ Yes ☐ No

Motor vehicle accident? ☐ Yes ☐ No If yes, what was the date of the accident: _______________

Can you perform your daily home activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some ☐ None at all

Describe your stress level: ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

Please list any previous surgeries, illnesses, injuries (including motor vehicle accidents): _____________

____

____

Have you ever had chiropractic care? ☐ Yes ☐No Doctor: ______________ Date: _______________

Family doctor name: ____

List ALL medications (prescriptions, vitamins, herbal supplements, BCP, aspirin, etc): _______________

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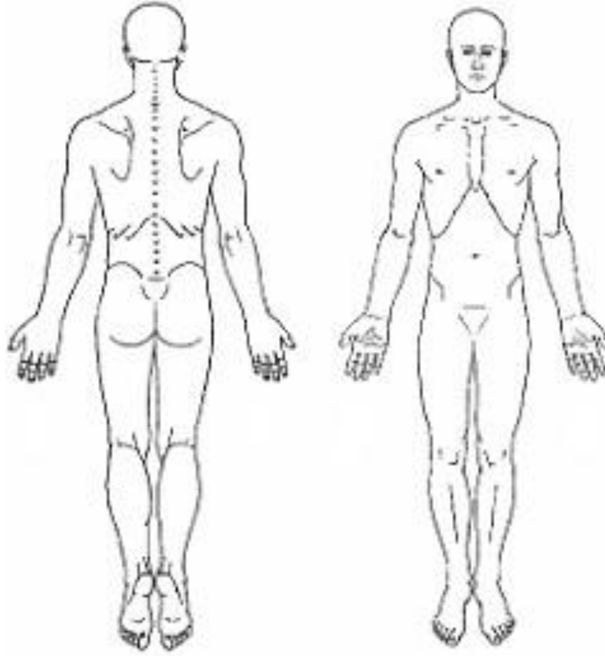
Date: ____________________________ Patient Signature: ____________________________________

Health History Questionnaire

Please indicate the location of your pain by shading in the appropriate areas.



Indicate the severity of the pain by circling a number.

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

Do you have diabetes? ☐ Yes ☐ No

Are you currently or have you ever been a smoker? ☐ Yes ☐ No

If yes, from ____________ (date) to _____________ (date).

Have you ever had cancer? ☐ Yes ☐ No

If yes, where? ________________________________ When? ______________________________

Have you ever had a whiplash injury (flexion-extension injury, cervical sprain) ? ☐ Yes ☐ No

Have you or any relatives ever suffered a stroke? ☐ Yes ☐ No

Have you ever experienced any numbness, loss of sensation, strength or weakness in the fingers, hands, arms, legs, or any other parts of the body? ☐ Yes ☐ No

Patient Signature: _____________________________________