CONSULTATION ADMITTANCE FORM

Last Name: _____ First Name: _____

Address: _____ City _____

Postal Code: _____ Home Phone: _____ Work Phone: _____

Age: _____ Birth date (dd/mm/yr): _____ Sex M/F Height _____ Weight _____

Occupation: _____ Alberta Health Care #: _____

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, MRI or other tests for this condition? What tests and when? _____

_____

Is this condition related to: Work? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Motor vehicle accident? ☐ Yes ☐ No Date of injury: _____

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	☐ Not 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 (motor vehicle accident): _____

_____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Doctor: _____ Date: _____

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

_____

I understand that Alberta Health Care coverage for chiropractic care represents only a portion of the Doctor's recognized fee schedule and that I am personally responsible for the balance of that fee.

Date: _____ Patient Signature: _____