**Consultation Admittance Form**

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| --- | --- | --- |
| Last Name: | First Name: | Gender: M / F |
| Address: | City, Province: | Postal Code: |
| Phone (Home) ( ) | Phone (Work) ( ) | Phone (Cell) ( ) |
| Alberta Health Care # | Third Party Insurance # |
| Emergency Contact Name: | Emergency Contact Phone ( ) |
| Date of Birth: | Age: | Height: | Weight: |
| Occupation: | Marital Status: Single Married Widowed Divorced |
| Email address: (optional) | (Email will be used for [ACAC member to customize, e.g., appointment reminders, receipts, birthday emails, etc.] ) |
|  |

**Please check all answers and fill in the blanks where appropriate.**

Reason(s) 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? [ ]  Yes [ ]  No Which tests, when?

Is this a work related injury? [ ]  Yes [ ]  No Has your employer been notified? [ ]  Yes [ ]  No

Is this a Motor Vehicle Accident (MVA)? [ ]  Yes [ ]  No On what date did the accident occur?

Can you perform daily home activities? [ ]  Yes [ ]  Yes, but only with help [ ]  Not at all

Can you perform your daily work activities? [ ]  All activities [ ]  Only some activities [ ]  Not at all

Describe your stress level [ ]  None [ ]  Mild [ ]  Moderate [ ]  High

Do you exercise? [ ]  Daily [ ]  Occasionally [ ]  Not at all

What kinds of exercise do you do?

List all previous surgeries, illnesses, injuries (including MVA):

Have you had previous chiropractic care? [ ]  Yes [ ]  No Dr. Date:

Family doctor name: Dr.

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.:

Date: Patient signature: