PATIENT ENTRANCE FORM

Name: ______________________________ Date: ______________

Street Address: ______________________________

City/Province: ______________________________ Postal Code: ______________

Primary Phone#: ______________ Alternate Phone#: ______________ Marital Status: ☐S ☐M ☐D ☐W

Date of Birth (D/M/Y): ______________ Age: ________ Email: ______________________________

Occupation: ______________________________

Employer: ______________________________

Employer Address: ______________________________

City/Province: ______________________________ Phone#: ______________

Spouse's Name: ______________________________ Children: ______________________________

Emergency Contact: ______________________________ Phone#: ______________

How did you hear about our office? ☐sign ☐website ☐friend/family: ______________________________

☐doctor/referral ☐other: ______________________________

CLAIM WILL BE MADE AGAINST:

1. Recent motor vehicle accident (MVA): ☐Yes ☐No (if Yes, see attached)
2. Work related injury/accident (WSIB): ☐Yes ☐No (if Yes, see attached)
3. Extended Health Care Plan (EHC): ☐Yes ☐No (if Yes, see below)
    a. EHC Company Name: ______________________________
    b. EHC Plan/Contract#: ______________________________
    c. EHC File/Certificate#: ______________________________

PRIOR CHIROPRACTIC CARE:

Name: ______________________________ Phone#: ______________

X-rays taken: ☐Yes ☐No Date: ______________________________

Results: ☐Excellent ☐Good ☐Fair ☐Poor

MEDICAL DOCTOR:

Name: ______________________________ Phone#: ______________

Address: ______________________________

Date of Last Appointment: ______________ Date of Last Physical: ______________

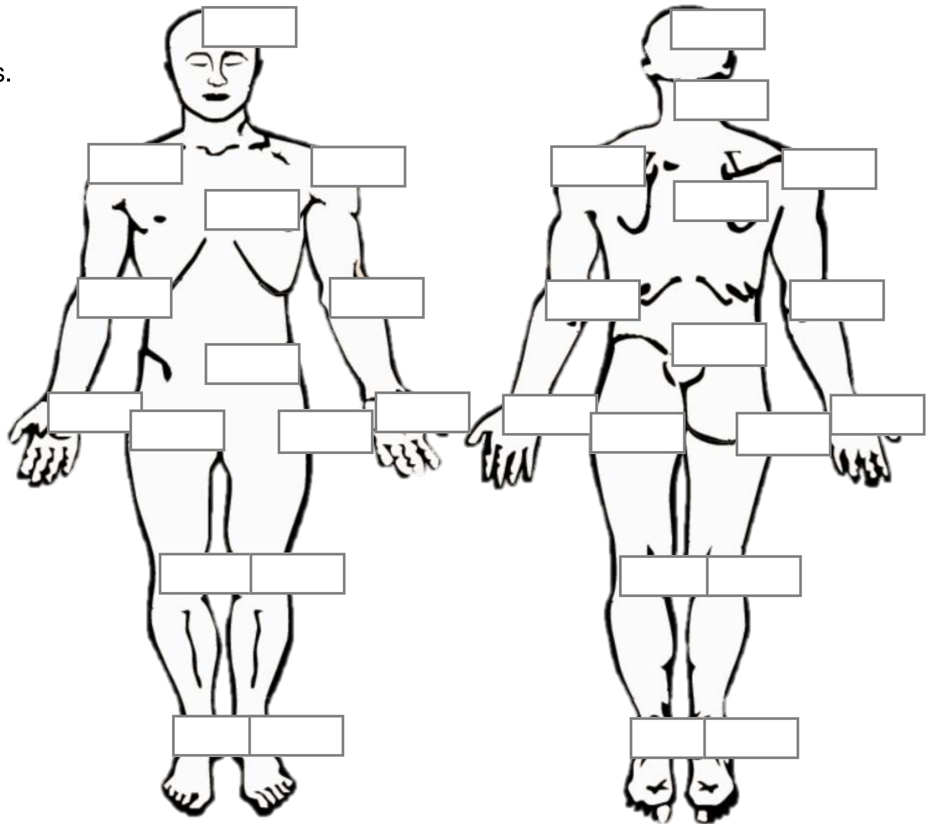
Reason for consulting this office:

Expectations: ____

Show area(s) of pain or unusual feeling

Use the drop-down arrows to mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	● ● ● ● ● ● ● ● ● ● ● ● ● ● ●
Pins & Needles	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Burning	X X X X X X X X X X X X X X X
Aching	* * * * * * * * * * * * * * *
Stabbing	/ / / / / / / / / / / / / / /



Have you ever had any of the following:

☐ Aneurysm ☐ Osteoporosis ☐ Diabetes ☐ Arthritis

Respiratory condition(s) ______________________ ☐ Epilepsy ☐ Cancer

☐ Stroke(s) Allergies ______________ Heart condition(s) ________________________

☐ Hepatitis ☐ Nerves ☐ Fatigue ☐ Polio

☐ Sleeping difficulty ☐ Pneumonia ☐ Pleurisy ☐ Covid-19

☐ Asthma ☐ S.T.D.(s) ☐ Psoriasis ☐ HIV

Sinus condition(s) __________________________

Childhood conditions had, please check:

☐ Measles ☐ Mumps ☐ Chicken pox ☐ Whooping cough

☐ Scarlet fever ☐ Diphtheria ☐ Rheumatic fever ☐ Typhoid fever

☐ Ear infection(s) ☐ Tubes in ears ☐ Chronic ill

PATIENT PAST HEALTH HISTORY FORM

Name: ______________________________ Date: ____________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional **F = Frequent** **C = Constant**

O	F	C	
☐	☐	☐	allergy
☐	☐	☐	chills
☐	☐	☐	convulsions
☐	☐	☐	dizziness
☐	☐	☐	fainting
☐	☐	☐	fevers
☐	☐	☐	headaches
☐	☐	☐	loss of sleep
☐	☐	☐	nervousness
☐	☐	☐	depression
☐	☐	☐	neuralgia
☐	☐	☐	numbness
☐	☐	☐	sweats
☐	☐	☐	loss of weight
☐	☐	☐	tremors

MUSCLE & JOINT

O	F	C	
☐	☐	☐	arthritis
☐	☐	☐	bursitis
☐	☐	☐	foot trouble
☐	☐	☐	hernia
☐	☐	☐	low back pain
☐	☐	☐	neck pain
☐	☐	☐	neck stiffness
☐	☐	☐	pain between shoulders

RESPIRATORY

O	F	C	
☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	spitting blood
☐	☐	☐	throat phlegm
☐	☐	☐	wheezing

EYES, EARS, NOSE & THROAT

O	F	C	
☐	☐	☐	colds
☐	☐	☐	crossed eyes
☐	☐	☐	deafness
☐	☐	☐	dental decay
☐	☐	☐	asthma
☐	☐	☐	ear aches
☐	☐	☐	ear discharges
☐	☐	☐	ear noises
☐	☐	☐	sinus infections
☐	☐	☐	enlarged glands
☐	☐	☐	enlarged thyroid
☐	☐	☐	sore throats
☐	☐	☐	tonsillitis
☐	☐	☐	eyepain
☐	☐	☐	failing vision
☐	☐	☐	far sighted
☐	☐	☐	gum trouble
☐	☐	☐	hay fever
☐	☐	☐	hoarseness
☐	☐	☐	nasal obstruction
☐	☐	☐	near sighted
☐	☐	☐	nosebleeds

CARDIO-VASCULAR

O	F	C	
☐	☐	☐	rapid heart beats
☐	☐	☐	slow heart beat
☐	☐	☐	swelling of ankles
☐	☐	☐	hardening of arteries
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	pain over heart
☐	☐	☐	poor circulation

PATIENT PAST HEALTH HISTORY FORM (continued)

Name: ____ Date: ______________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional **F = Frequent** **C = Constant**

O F C

GASTRO INTESTINAL

☐ ☐ ☐ excessive hunger
☐ ☐ ☐ burping or gas
☐ ☐ ☐ liver trouble
☐ ☐ ☐ colitis
☐ ☐ ☐ colon trouble
☐ ☐ ☐ constipation
☐ ☐ ☐ diarrhea
☐ ☐ ☐ difficult digestion
☐ ☐ ☐ distension of abdomen
☐ ☐ ☐ stomach pain
☐ ☐ ☐ gall bladder trouble
☐ ☐ ☐ hemorrhoids
☐ ☐ ☐ intestinal worms
☐ ☐ ☐ jaundice
☐ ☐ ☐ poor appetite
☐ ☐ ☐ nausea
☐ ☐ ☐ vomiting
☐ ☐ ☐ vomit blood

SKIN

☐ ☐ ☐ boils
☐ ☐ ☐ bruise easily

O F C

☐ ☐ ☐ dryness
☐ ☐ ☐ hives or allergy
☐ ☐ ☐ itching
☐ ☐ ☐ skin rash
☐ ☐ ☐ varicose veins

GENITO-URINARY

☐ ☐ ☐ betwetting
☐ ☐ ☐ blood in urine
☐ ☐ ☐ frequent urination
☐ ☐ ☐ loss control urine
☐ ☐ ☐ kidney infection
☐ ☐ ☐ painful urination
☐ ☐ ☐ prostate trouble
☐ ☐ ☐ pus in urine
☐ ☐ ☐ smell of urine

PAIN OR NUMBNESS IN:

☐ ☐ ☐ shoulders
☐ ☐ ☐ arms
☐ ☐ ☐ hands
☐ ☐ ☐ hips
☐ ☐ ☐ legs

O F C

☐ ☐ ☐ knees
☐ ☐ ☐ ankles
☐ ☐ ☐ feet
☐ ☐ ☐ painful tail bone
☐ ☐ ☐ sciatica
☐ ☐ ☐ swollen joints

FOR WOMEN ONLY

☐ ☐ ☐ cramps
☐ ☐ ☐ heavy flow
☐ ☐ ☐ light flow
☐ ☐ ☐ irregular cycle
☐ ☐ ☐ painful cycle
☐ ☐ ☐ discharge
☐ ☐ ☐ sore breasts

Menopausal: ☐ Yes ☐ No

Last menstruation date:

____

Pregnant: ☐ Yes ☐ No

Due date: ______________

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: ☐ Yes ☐ No   Do you consume alcohol: ☐ Yes ☐ No

Do you exercise: ☐ Yes ☐ No   Exercise Indoor Activities: ______________________________

How many hours/week: ____________________   Exercise Outdoor Activities: ______________________________

Rate your sleep, hours per night: ☐ 4 – 6 , ☐ 6 – 8 , ☐ 8 – 10 , ☐ 12+

Do you wake rested: ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4 meals ☐ More than 4 meals

Date of last Dental Examination: ____

Falls and Accidents – list: ____

____

Surgery and Operations – list: ____

____

Do you take vitamins and minerals, list: ☐ Yes ☐ No

____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't know

If so, for how long and when: ____

List any medication or drugs you are currently taking: ______________________________________

____

____

Have you previously been hospitalized: ☐ Yes ☐ No

Please list: ____

Any family health conditions or problems: ☐ Yes ☐ No

Please list: ____

PLEASE NOTE - In order to diagnose your condition(s) and recommend treatments options, physical examinations will be performed to reproduce your primary complaint and, as such, may temporarily aggravate your symptoms. By signing this form, you are confirming the accuracy of your medical history and consent to physical examinations as required to diagnose your current and future symptoms.

Signature: ____   Date: ____________________________

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name:________________________________File #_______________________Date: ___________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain lam unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECT ION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING

- ☐ I get no pain whilst traveling.
- ☐ I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better,
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain-is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

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

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name:_______________________________File #______________Date_____________

PLEASE READ INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is the worst imaginable at the moment

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally, but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help, but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do no get dressed, I wash with difficulty, and stay in bed

SECTION 3 – LIFITNG
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

SECTION 4 – READING
- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want to with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

SECTION 5 – HEADACHES
- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

SECTION 7 – WORK
- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

SECTION 8 – DRIVING
- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

SECTION 9 – SLEEPING
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less that 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – RECREATION
- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

PAIN SCALE:

Rate the severity of your pain by checking ONE box on the following scale.

No pain	1	2	3	4	5	6	7	8	9	10	*Excruciating pain*