Consultation Admittance Form Gilbertson Chiropractic ®

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: _____

Systems Review

Patient Name: _____ **Date:** _____

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS

Fever
Sweats
Fainting
Sleep disturbance
Fatigue
Nervousness
Weight loss
Weight gain

NEUROLOGICAL

Visual disturbance
Dizziness
Fainting
Convulsions
Headache
Numbness
Neuralgia (nerve pain)
Poor coordination
Weakness

EYES, EARS, NOSE, THROAT

Eye pain
Double vision
Ringing in ears
Deafness
Nosebleeds
Trouble swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Wheezing
Difficulty breathing
Asthma

CARDIOVASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Swollen ankles
Poor circulation
Palpitations
Cold hand or feet
Varicose veins

MUSCLE & JOINT

Neck pain
Low back pain
Arm pain
Shoulder pain
Leg pain
Knee pain
Foot pain
Pain/numbness down arms or legs
Pain between shoulders
swollen joints
Spinal curvature
Arthritis
Fractures

GENITOURINARY

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Prostate trouble
Uncontrollable urine flow

GASTROINTESTINAL

Poor appetite
Difficult digestion
Heartburn
Ulcers
Nausea
Vomiting
Constipation
Diarrhea
Blood in stool
Gallbladder/jaundice
Colitis

FOR WOMEN ONLY

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week?
Other:

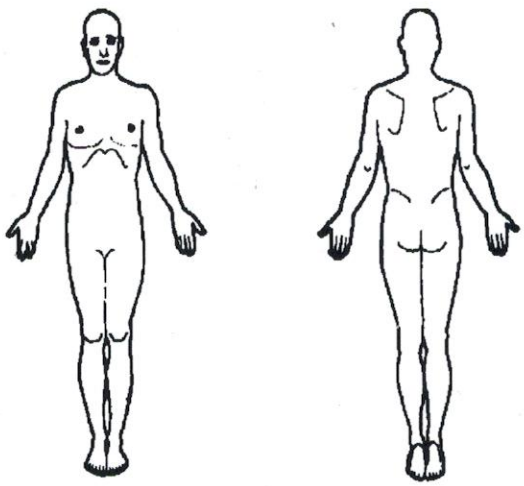
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------- Yes No
2. Hardening of the arteries (arteriosclerosis) ---------- Yes No
3. Diabetes ---------- Yes No
4. Tuberculosis ---------- Yes No
5. Cancer ---------- Yes No
   Where? _____
6. Heart or blood diseases ---------- Yes No
7. Bone spurs on the neck bones (cervical sprain) ---------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) ---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From _____ to _____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision) ---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
14. Slurred speech or other speech problems ---------- Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------- Yes No
19. Sudden collapse without loss of consciousness ---------- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain