Lockport Family Chiropractic

Health & Wellness Centre

PATIENT ENTRANCE FORM

Name: _____ Date: _____

Address: _____
(Street) (City) (Province) (Postal Code)

Home Phone: _____ Cell Phone: _____

Date of Birth (D/M/Y): _____ Age: _____ Marital Status: S M D W

Spouses Name: _____ Children: _____

Occupation: _____

Employer: _____

Address: _____
(Street) (City) (Province) (Postal Code)

Emergency Contact: _____ Phone: _____

Manitoba Health #: _____ P.H.I.N.# _____

How did you hear about our office: Friend ____ Phone Book ____ Sign _____ Other _____

Will claim be made against:

1. Recent motor vehicle accident: Yes _____ No _____ (if Yes, see attached)
2. Work related injury/accident: Yes _____ No _____ (if Yes, see attached)

Prior Chiropractic care

Name: _____ Phone: _____

How many visits since the first of this year: _____ Did you receive relief: Y / N

X-rays taken: Yes _____ No _____ Date: _____

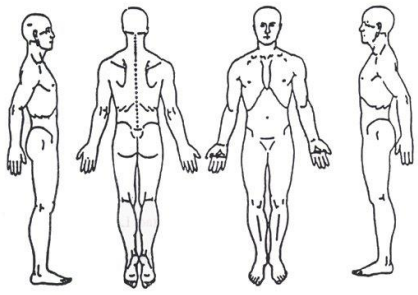
Medical Doctor

Name: _____ Phone: _____

Address: _____

Date of last appointment: _____ Date of last physical: _____

Describe your Complaint/Problem/Injury
Mark areas of pain/discomfort



Is this interfering with your: ☐ Work ☐ Sleep
☐ Exercise ☐ Daily Activities
☐ Other: _____

Which activities aggravate your condition?
☐ Bending ☐ Lifting ☐ Sitting ☐ Standing
☐ Coughing ☐ Sneezing ☐ Driving ☐ Exercise
☐ Other: _____

Which activities relieve your condition?
☐ Rest ☐ Moving About ☐ Cold Pack ☐ Heat

Other professionals consulted for this condition?

When did this problem begin?

Have you had this in the past? _____
When? _____

Is it getting: ☐ Worse ☐ Same ☐ Better

Pains are: ☐ Sharp ☐ Dull ☐ Achy
☐ Stabbing

Medical Tests, X-rays, MRI or CT scans for this condition?

Other health problems? _____

Pain Scale: On a scale of **0** (no pain) to **10** (worst pain ever), how do you rate your pain level:

Right now: 0 1 2 3 4 5 6 7 8 9 10 **At its Worst:** 0 1 2 3 4 5 6 7 8 9 10 **At its Best:** 0 1 2 3 4 5 6 7 8 9 10

Medication/Drugs/Pain Killers you now use: _____

Circle any of the following that affect you: Diabetes Cancer Asthma Fractures Heart Disease Heart Attack High/Low Blood Pressure Psychological Disorder Epilepsy Fainting Hepatitis Lupus Unexplained Weight Loss Osteoporosis Arthritis Seizures

WE ACCEPT PAYMENT BY CASH, CHEQUE, CREDIT CARD AND DEBIT

I understand that all services are to be paid in full at the time of service and
I am responsible for billing my private insurance, if necessary.

Date: _____ **Signature of Patient/Guardian:** _____