Meadowlark
Chiropractic

Consultation Admittance Form

Last Name:	First Name:	Gender:
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )

Alberta Health Care #			
Emergency Contact Name:		Emergency Contact Phone ( )	
Date of Birth:	Age:	Height:	Weight:
Occupation:		Marital Status: Single Married Widowed Divorced	
Email address: (optional)			

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

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

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

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

_____

_____

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

Family doctor name: Dr. _____ Phone Number: _____ Email: _____

Do you consent to our office contacting your family doctor if necessary? ☐ Yes ☐ No

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

_____

_____

Date: _____ Patient signature: _____

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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	**RESPIRATORY**	**GENITOURINARY**
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Sleep disturbance	Spitting up blood	Blood in urine
Fatigue	Chest pain	Pus in urine
Nervousness	Wheezing	Kidney infection
Weight loss	Difficulty breathing	Prostate trouble
Weight gain	Asthma	Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Pain over heart	Ulcers
Headaches	Hardening of arteries	Nausea
Numbness	Swollen ankles	Vomiting
Neuralgia (nerve pain)	Poor circulation	Constipation
Poor coordination	Palpitations	Diarrhea
Weakness	Cold hands or feet	Blood in stool
	Varicose veins	Gallbladder/jaundice
		Colitis
EYES, EARS, NOSE THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down the	Menopausal symptoms
Nasal drainage	arms or legs	Birth control pills
Enlarged glands	Pain between the shoulders	Miscarriages
	Swollen joints	Complications with
	Spinal curvature	pregnancy
	Arthritis	Pregnant? Y / N Week:
	Fractures	Other:

Meadowlark
Chiropractic

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. Stroke or family history of stroke---------- Yes No
4. Heart disease including heart attacks, irregular heart beat, valve defects or disease, congestive heart failure or other problems---------- Yes No
5. Blood diseases (e.g. clotting disorder, haemophilia or others) ---------- Yes No
6. Diabetes---------- Yes No
7. Tuberculosis, AIDS, or Hepatitis ---------- Yes No
8. Cancer ---------- Yes No
   Type and location:
9. Any type of arthritis---------- Yes No
   Type and location:
10. Unexplained weight loss---------- Yes No
11. Enlarged glands---------- Yes No
12. Digestive issues or disease---------- Yes No
13. Were you ever a smoker? How long? ( )---------- Yes No
14. Alcoholism---------- Yes No
15. Drug use other than prescription medications? ---------- Yes No
16. Depression, schizophrenia, or other psychiatric disease---------- Yes No
17. Are you taking (or have you taken) immunosuppressant or steroid based medications? ---------- Yes No
18. Visual disturbances (blurring, loss or temporary loss, double vision) Yes No
19. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
20. Slurred speech or other speech problems ---------- Yes No
21. Difficulty swallowing ---------- Yes No
22. Dizziness or vertigo---------- Yes No
23. Sudden collapse or loss of consciousness, even momentary blackouts ---------- Yes No
24. 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
25. Have you or any of your relatives suffered from aneurysms or arterial dissections? ---------- Yes No

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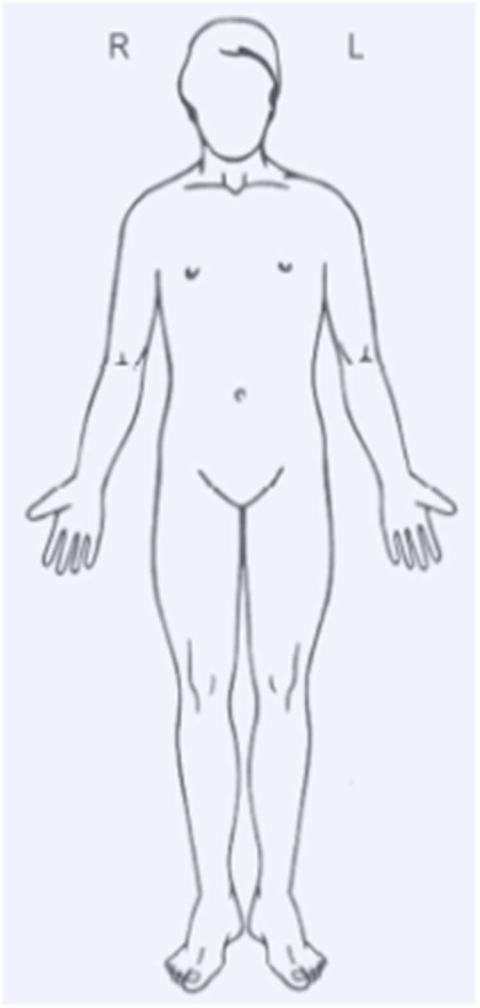
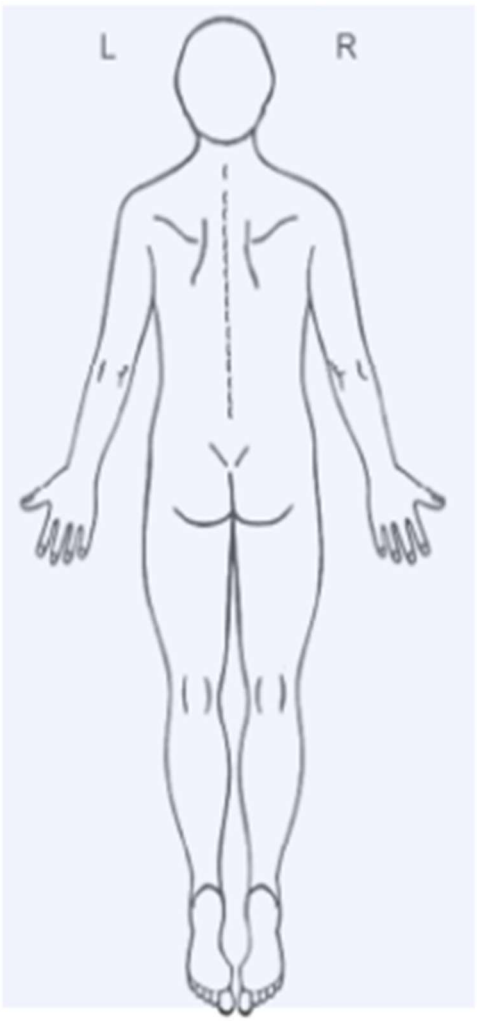
Use the symbols below to mark all the areas on the diagram that best represent your pain.

Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Front



Back

Please 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