THE REHAB CENTRE

Maple's premier rehab and wellness centre

PATIENT ENTRANCE FORM

DATE dd_____ mm_____ yyyy_____

LAST NAME (MR. MS. MRS.) _____

FIRST NAME _____ GENDER M ☐ F ☐

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

CELL PHONE ( ) _____ EMAIL ADDRESS _____

DATE OF BIRTH dd_____ mm_____ yyyy_____ AGE _____

EXTENDED HEALTH CARE COMPANY _____

POLICY NUMBER _____ I.D. # _____

Is there a secondary source of extended benefits?: Y ☐ N ☐ If yes, with whom _____

OCCUPATION _____

MARITAL STATUS - S M D W S SPOUSE'S NAME _____ CHILDREN _____

CLOSEST RELATIVE (In case of emergency) _____ PHONE ( ) _____

HOW DID YOU HEAR ABOUT OUR OFFICE?: sign ☐ advertise ☐ phone book ☐ other ☐ _____
referral ☐ (whom) _____

IS YOUR CONDITION DUE TO AN ACCIDENT?: Y ☐ N ☐ (check below if Yes)

1. Recent Motor Vehicle Accident: Y ☐ N ☐ (If Yes, obtain MVA form)
2. Work related injury / accident: Y ☐ N ☐ (If Yes, obtain WSIB form)

PRIOR CHIROPRACTIC CARE:

NAME _____ PHONE ( ) _____

Date of Last Treatment _____ Were you on maintenance care? Y ☐ N ☐

Reason stopped care _____

MEDICAL DOCTOR:

NAME _____ PHONE ( ) _____

Date of Last Appointment _____ Date of Last Physical _____

List any medications and/or supplements you are taking _____

Females: Are you Pregnant?: ☐ Y ☐ N Are you on birth control pills? ☐ Y ☐ N

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Major complaints: (check the most bothersome and circle the severity)

☐ _____
(no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

☐ _____
(no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

☐ _____
(no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

☐ _____
(no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

How long have you had this complaint? _____

Did you ever have a similar problem? _____

What time of day is it worse? _____

Did it appear: ☐ Slowly ☐ Suddenly

Does it wake you at night? ☐ Y ☐ N

What makes your condition better? _____

What makes your condition worse? _____

Who have you seen for your symptoms?

☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other _____

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays date:_____ ☐ CT Scan date:_____

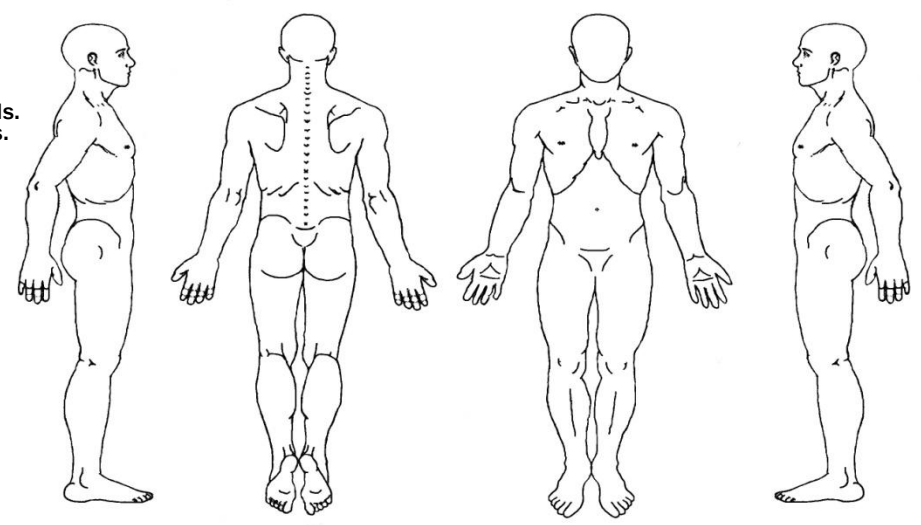
☐ MRI date:_____ ☐ Other date:_____

Draw in your face

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensation. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Burning
* * * * * *	X X X X X
* * * * * *	X X X X X
Pins & Needles	**Aching**
0 0 0 0 0 0 0 0	+ + + + +
0 0 0 0 0 0 0 0	+ + + + +
Sharp	**Shooting**
/ / / / /	^ ^ ^ ^
/ / / / /	^ ^ ^ ^



HAVE YOU HAD ANY?:

			Date
Automobile accidents	☐ Y	☐ N	_____
Surgeries	☐ Y	☐ N	_____
Broken bones	☐ Y	☐ N	_____
Falls/Head injuries	☐ Y	☐ N	_____

STRESSORS

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week _____

☐ Coffee/Caffeine drinks Cups/Day _____

☐ High Stress Level Reason _____

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

Check any of the following conditions you have had:

☐ AIDS/HIV	☐ Chronic fatigue	☐ Heart disease	☐ Leg/calf pain	☐ Respiratory problems
☐ Allergies	☐ Deafness	☐ Hepatitis	☐ Loss of consciousness	☐ Shingles
☐ Aneurysm	☐ Diabetes	☐ Herniated disc	☐ Osteoporosis	☐ Stroke
☐ Anxiety/Depression	☐ Digestion problems	☐ High blood pressure	☐ Poor circulation	☐ Thyroid problems
☐ Arthritis	☐ Ear ringing	☐ Insomnia	☐ Prostate problems	☐ TMJ
☐ Asthma	☐ Epilepsy	☐ Irregular cycle	☐ Psoriasis	☐ Venereal disease
☐ Cancer	☐ Headaches/Migraines	☐ Kidney problems	☐ Rheumatoid arthritis	☐ Vertigo/dizziness