Align Health & Wellness
Suite 226, 4411 – 16th Avenue NW, Calgary, Alberta T3B 0M3

PATIENT ENTRANCE FORM

Last Name: _____ First Name: _____ Date: _____

_____
Address City, Province Postal Code

Ph. # _____ Cell # _____ Email _____

Prov. Health Card Number: _____

Date of Birth (D/M/Y) ___/___/_____ Gender M / F Age _____ Marital Status – S M C D Sep W

Spouse's Name _____ Children_____

Emergency Contact_____ Phone _____

Occupation (Your) _____ Employer _____

City _____ Phone _____

Who referred you to our office? _____

Have you had a recent motor vehicle accident (□ Yes □ No) or work related accident (□ Yes □ No)?

Reason for consulting our office: _____

Expectations: _____

PRIOR CHIROPRACTOR: _____ Phone: _____

X-rays taken: YES NO If yes, when: _____ What areas: _____

Results Achieved: Excellent Good Fair Poor

MEDICAL DOCTOR: _____ Phone: _____

Date of Last Appointment: _____ Date of Last Physical: _____

MEDICAL SPECIALIST: _____ Phone: _____

Specialty: _____Date of Last Appointment: _____

DENTIST: _____ Phone: _____

Location: _____Date of Last Appointment: _____

DENTAL SPECIALIST: _____ Phone: _____

Specialty: _____Date of Last Appointment:_____

Past Dental Procedures: _____

Patient/Legal Guardian Signature: _____ Date: _____

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Last Name: _____ First Name: _____

NATUROPATH: _____ Phone: _____

Practice Location: _____

MASSAGE THERAPIST: _____ Phone: _____

Practice Location: _____

PHYSICAL THERAPIST: _____ Phone: _____

Practice Location: _____

DIAGNOSTIC PROCEDURES:

Please list X-ray, MRI, CT, and ultrasound studies that have been performed in the past 3 years:

Date: Procedure: Area Examined: Results:

_____

_____

_____

DIRECT BILLING OPTIONS

Do you have extended health coverage? □ Yes □ No

For direct billing to your insurance company:

MasterCard **#**_____ Exp. _____ Validation Code: _____
M M / Y Y

Visa **#**_____ Exp. _____ Validation Code: _____
M M / Y Y

Blue Cross Plan #_____ Group # _____

GreenShield Plan #_____ Group # _____

SSQ Plan #_____ Group # _____

Empire Life Plan #_____ Group # _____

Plan Member Name: _____ Date of Birth: _____
D D / M M / Y Y Y Y

Relationship to Plan Member: _____

Patient/Legal Guardian Signature: _____ Date: _____

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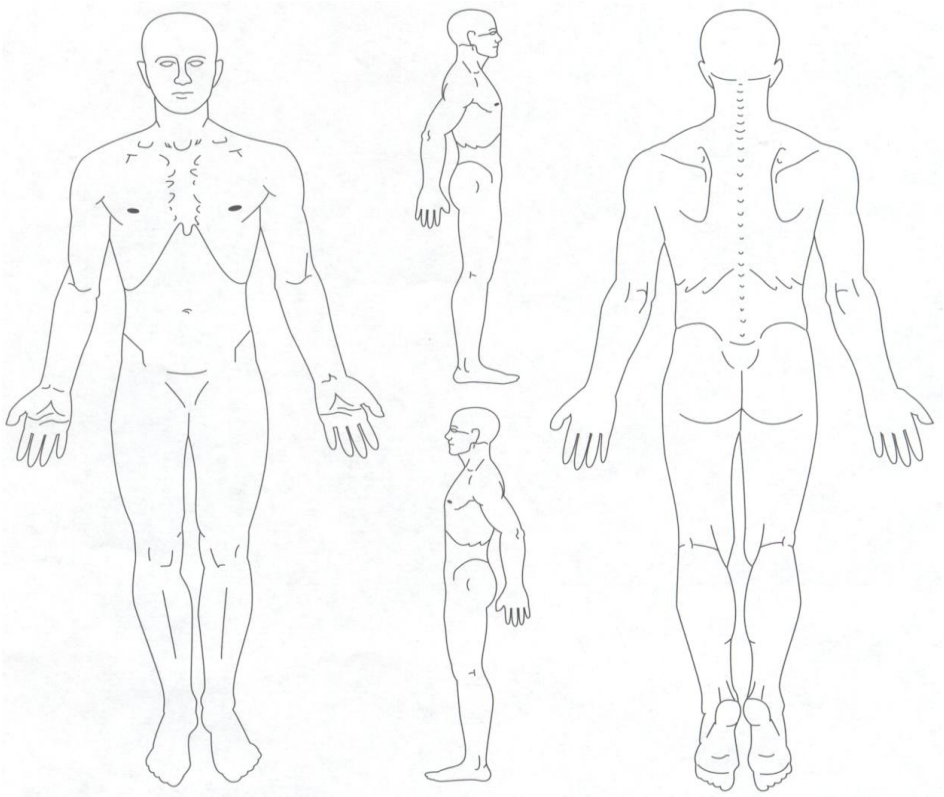
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Sharp
T = Tingling (Pins & Needles)
C = Cramping



Please reflect on your **sense of well-being**, taking into account your physical, mental, emotional, social, and spiritual condition **over the past one month**. Use an X on the line to mark your answer to the question.

Mark the line below with an X at the point that summarizes your **overall sense of well-being** for the past one month.

Worst you have ever been — Best you have ever been

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PAST HISTORY (Please check appropriate box for any symptoms that you have experienced within the last year)

C = Constant F = Frequent (*weekly*) O = Occasional (*monthly/yearly*)

NEUROLOGICAL

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

MUSCLE & JOINT

❑	❑	❑	arthritis
❑	❑	❑	bursitis
❑	❑	❑	foot trouble
❑	❑	❑	hernia
❑	❑	❑	low back pain
❑	❑	❑	neck pain
❑	❑	❑	neck stiffness
❑	❑	❑	pain between shoulders

RESPIRATORY

❑	❑	❑	chest pain
❑	❑	❑	chronic cough
❑	❑	❑	difficulty breathing
❑	❑	❑	spitting blood
❑	❑	❑	throat phlegm
❑	❑	❑	wheezing

EYES, EARS, NOSE & THROAT

❑	❑	❑	colds
❑	❑	❑	crossed eyes
❑	❑	❑	deafness
❑	❑	❑	dental decay
❑	❑	❑	asthma
❑	❑	❑	ear aches
❑	❑	❑	ear noises
❑	❑	❑	sinus infections
❑	❑	❑	enlarged glands
❑	❑	❑	enlarged thyroid
❑	❑	❑	sore throat
❑	❑	❑	tonsillitis
❑	❑	❑	eye pain
❑	❑	❑	failing vision
❑	❑	❑	far sighted
❑	❑	❑	gum trouble
❑	❑	❑	hay fever
❑	❑	❑	hoarseness
❑	❑	❑	nasal obstruction
❑	❑	❑	near sighted
❑	❑	❑	nosebleeds

CARDIO-VASCULAR

❑	❑	❑	rapid heart beats
❑	❑	❑	slow heart beats
❑	❑	❑	swelling of ankle
❑	❑	❑	hardening of arteries
❑	❑	❑	high blood pressure
❑	❑	❑	low blood pressure
❑	❑	❑	pain over heart
❑	❑	❑	poor circulation

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

C	F	O	
❑	❑	❑	boils
❑	❑	❑	bruise easily
❑	❑	❑	dryness
❑	❑	❑	hives or allergy
❑	❑	❑	itching
❑	❑	❑	skin rash
❑	❑	❑	varicose veins

GENITO-URINARY

❑	❑	❑	bed wetting
❑	❑	❑	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
❑	❑	❑	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/Legal Guardian Signature: _____ Date: _____

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PAST HISTORY FORM (continued), HABITS OF LIFESTYLE:

Do you smoke: ❑ Yes ❑ No Alcohol Consumption: ❑ Yes ❑ No ❑ Rarely

Do you exercise: ❑ Yes ❑ No Exercise Activities: _____

Do you drink beverages with caffeine: ❑ Yes ❑ No If yes, how many cups/glasses daily: _____

How many glasses of water do you drink per day: 0 – 4 4 - 8 8 - 12 12+

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

Do you wake rested: ❑ Yes ❑ No

Do you feel overly fatigued during the course of a day: ❑ Yes ❑ No

Rate your appetite: Poor Fair Medium Good Excellent

Do you eat regularly: ❑ Breakfast ❑ Lunch ❑ Dinner

Significant Falls and Accidents, list:_____

_____

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

If so, for how long: _____

Surgery and Operations, list: _____

_____

List vitamins and minerals that you take: _____

List any medication (dosage/frequency) you are currently taking:_____

_____

Have you previously been hospitalized: ❑ Yes ❑ No

Reason: _____

Any family health conditions or problems: ❑ Yes ❑ No

Please list: _____

Patient/Legal Guardian Signature: _____ Date: _____

PATIENT ENTRANCE FORM

Last Name: _____ First Name: _____

REVIEW OF CONDITIONS (It is critical that you check all that apply)

HEADACHES: How long have you had headaches? _____ Why did these headaches begin? _____
Do you consider this headache to be ❑ migraine ❑ neck related ❑ jaw related
❑ or other (list) _____
How long do the headaches last (give a number or range)? ____ hours ____ days
or it varies (explain) _____
❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Front ❑ Back ❑ Left Side ❑ Right Side ❑ Entire Head
These headaches: ❑ are localized ❑ originate from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your headache better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

CERVICAL (Neck): How long have you had neck issues? _____ Why did this neck issue begin? _____
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Top of neck ❑ Base of neck ❑ Left Side ❑ Right Side ❑ Entire Neck
The neck discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your neck discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

SHOULDERS: How long have you had shoulder issues? _____ Why did this issue begin? _____
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The shoulder discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your shoulder discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

THORACIC (MID BACK): How long have you had mid back issues? _____ Why did this issue begin? _____
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The mid back discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your low back discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

Patient/Legal Guardian Signature: _____ Date: _____

PATIENT ENTRANCE FORM

Last Name: _____ First Name: _____

REVIEW OF CONDITIONS (cont'd) (It is critical that you check all that apply)

LUMBAR (LOW BACK): How long have you had low back issues? _____ Why did this issue begin? _____
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The low back discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your low back discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

UPPER EXTREMITIES: How long have you had this issue? _____ Why did this issue begin? _____
Area involved: ❑ shoulders ❑ upper arm ❑ elbow ❑ lower arm ❑ wrist ❑ hand
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

HIPS: How long have you had hip issues? _____ Why did this issue begin? _____
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The hip discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your hip discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

LOWER EXTREMITIES: How long have you had this issue? _____ Why did this issue begin? _____
Area involved: ❑ hips ❑ thigh ❑ knee ❑ lower leg ❑ ankle ❑ foot
Please describe as: ❑ Ache ❑ Stiff ❑ Tight ❑ Spasm ❑ Sharp ❑ Numbness ❑ Other
How often does this pain occur? ❑ Constant ❑ Daily ❑ Weekly ❑ Monthly
❑ or is irregular (explain) _____
What area is involved? ❑ Left ❑ Right ❑ Both
The discomfort: ❑ is localized ❑ originates from another location (where?) _____
❑ travels to another location (where?) _____
Things that make your discomfort better? _____ worse? _____
The average severity of the pain associated with this symptom:
No pain I----------I Severe

Patient/Legal Guardian Signature: _____ Date: _____