File # _______

Treating Doctor/Therapist:____

CORNELL CHIROPRACTIC CENTRE

"Improving the health of our community"

PATIENT ENTRANCE FORM

Name: ____ Male / Female Date: ___________

Address: ____

City, Province: ________________________ Postal Code: ____________ Email: ___________________________

Phone #: ________________________ Business: _______________________ Cell: _____________________

Date of Birth (dd/mm/yyyy): ___________________ Age: _______ Marital Status – S M D W

Spouse's Name: ____________________________________

Child(ren)'s Name(s): ____

Occupation: ____

Employer: ____

Closest Relative's Name and Relation: ____

His/Her Phone #: ________________________ Work #: ________________________

How did you hear about our office? (Please include name if applicable)

Phone Book: _____ Flyer: _____ Website: _____ Referred (His/Her Name): ____________________________

Medical Doctor:

Name: _____________________________________ Telephone: ____________________

Date of last appointment: _____________________ Date of last physical: ____________________

List all medications that you are currently taking: ____

____

Do you currently wear custom orthotics? Y / N If so, how old are they? ______

LIFESTYLE

Do you smoke? YES NO How many cigarettes per day? ___________

Number of alcoholic drinks per week: _________

Do you exercise regularly? YES NO

How many times per week, and what activities? ____

____

Rate your diet:	poor	fair	good	excellent
Rate your sleeping habits:	poor	fair	good	excellent

Height: _________ Weight: _________ Handed: R: _____ L: _____

Please list the vitamins or other nutritional supplement that you currently take: ________________________________

____

Surgery / Major Injuries / Car Accidents (Dates): ____

____

File # _______

Treating Doctor/Therapist:____

List any family health conditions or problems: ____

____

Please **circle** any of YOUR **current** conditions, and put a *check* beside any of YOUR *past* conditions.

cancer	diabetes	heart disease	stroke
epilepsy	hepatitis	arthritis	psoriasis
loss of vision	depression	prostate problems	high/low blood press
osteoporosis	HIV	allergies	headaches dizziness
fainting	appetite loss	asthma	extreme thirst
night pain	constipation	thyroid problems	kidney stones
anxiety attacks	chronic cough	ringing in ears	chest pain
IBS	pacemaker	infectious skin conditions	pins/plates
blood conditions	joint reconstruction		

For females:

Painful menstruation   irregular cycles   heavy flow   cramps

# of pregnancies: ______   Are you pregnant? Y or N   Are you currently trying to get pregnant? Y or N

Menopausal? Y or N   Are you on hormone replacement therapy? Y or N

Do you take birth control pills? Y or N

In the diagram below, please mark the areas on your body which you feel best represents the pain(s) or sensation(s) you are experiencing. Please include all areas. Use symbols provided below.

Symbols:

Numbness: 111

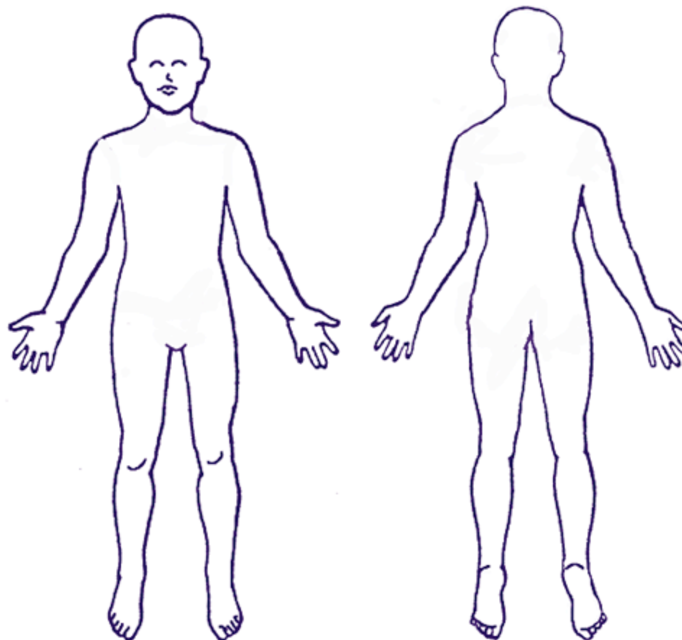
Burning: xxx

Dull & Aching +++

Pins & needles ***

Stabbing & sharp /////

Stiff & tight 222



I consent to an initial examination and Gait Scan to be performed by a Doctor or Massage Therapist at the Cornell Chiropractic Centre.

Signed ________________________   Date: _______________