73 Goulet St
Winnipeg, MB
R2H 0R5
204-237-6726

Connect CHIROPRACTIC

Dr. Trevor Clark
Dr. Jane Peterson

Patient Entrance Form

QOL:

Name: _____ Date: _____

Address: _____ City:_____ Postal Code: _____

Cell Phone Number: _____ Home Phone Number: _____

Email: _____ Occupation: _____

Date of Birth:(M/D/Y)____ /____ /____ Age: ____ Married □ Single □ Widowed □ Divorced □ Children _____

Name of Family Doctor: _____ Referred By: _____

Emergency Contact: _____ Phone #: _____

What symptom(s) brought you in today? (List in order of severity… 0-10, 0=no pain 10=severe pain)

1) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

2) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

3) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

Is your problem the result of: □ Auto Accident □ Work Accident □ Slip & Fall

Aggravating Factors:

□ Cough □ Sneeze □ Lifting □ Bending □ Twisting

□ Sitting □ Standing □ Walking □ Driving

□ Stairs Up □ Stairs Down □ Getting up from chair

□ Getting in /out of car

Relieving Factors:

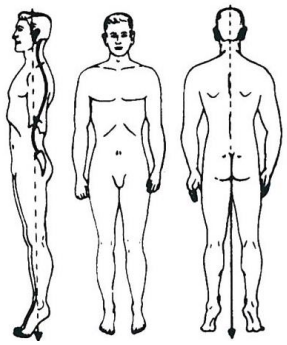
□ Ice □ Heat □ Massage □ Stretching

□ Sitting □ Standing □ Laying Down

□ Other: _____

Previous Treatments: □Chiropractor □Physiotherapy □Massage □ Other: _____

Last treatment date: _____



Please Circle Area(s) of Pain

Motor Vehicle Accidents: □ Yes □ No Injury date: _____Claim # if this is MPI case: _____

Is this a WCB case? □ Yes □ No Injury date: _____ WCB Claim #:_____

Info Regarding any Previous Trauma: _____

Surgeries: □ Yes □ No When: _____

Fall on Tailbone □ Yes □ No When: _____ **Hit to the Head** □ Yes □ No When: _____

Slips and/or Falls: □ Yes □ No _____ When: _____

Do you play or have you previously played any sports? □ Yes □ No **Details:** _____

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Previous Diagnosis:

Arthritis Cancer Hypertension Diabetes Heart Disease Skin Disorder Depression Anxiety

Fibromyalgia TMJ Disc Herniation Allergies Psychological Lung Disorder Stroke

Hereditary Factors (Describe family history):_____

Medications:_____

Please Mark All That Apply Currently:

Blood Pressure		Hepatitis		Eczema	
Chest Pain		Easy Bruising		Psoriasis	
Palpitations		Coughing		Skin Reaction	
Swelling		Asthma		Liver Disease	
Cloudy Head		Allergies		Thyroid Disease	
Loss of Memory		Herniated Disc		Frequent Colds	
Problems Concentrating		Shortness of Breath		Diabetes	
Kidney Stones		Ringing in Ears		Fatigue	
Bladder Infection		Dizziness		Gout	
Frequent Urination		Hearing Loss		Mood	
Stomach		Sinus		Arthritis	
Gall Bladder		Balance		Jaw Problems	
Constipation		Headaches		Osteoporosis	
Diarrhea		Eyewear		Breast Lump	
Gas		Glaucoma		Menstrual Pain	
Heartburn		Prostate Problems			
Vomiting		# of Pregnancies		Weight (lbs) :	
Alcohol: drinks/week		Smoking: packs/day		Coffee: cups/day	

Rate Your Level of Stress (Circle): Absence 1 2 3 4 5 6 7 8 9 10 Extreme

Rate Your Level of Energy (Circle): Absence 1 2 3 4 5 6 7 8 9 10 Extreme

Rate Your Quality of Sleep (Circle): Absence 1 2 3 4 5 6 7 8 9 10 Extreme

Please initial following Disclosures of Personal Health Information

___(initial) We are concerned with protecting the privacy of your personal health information. The law requires us to notify you about this disclosure. It may be necessary for us to disclose your health information to another health care provider if it is necessary to them for the diagnosis, assessment, or treatment of your health condition**.** I give Connect Chiropractic and its representatives permission to communicate with me via the contact information provided.

___(initial) I consent to a professional chiropractic examination and to any radiographic examination that the doctor deems necessary. Females: I confirm to the best of my knowledge that I'm not pregnant which would exclude me from any radiographic examination.

Patient or Guardian Signature: _____ **Date:** _____