Mount Forest Chiropractic
Michelle A. Gross, B.Sc. (Hons.), D.C.
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Brianne O'Driscoll, B.Sc., D.C

Patient Entrance Form

File #: ______________________

Name ____ Date ____________________________

Date of Birth_______ / ______ / _______ Age ________ Marital Status ________________
DAY MONTH YEAR

Home Address _______________________________ Town __________________________________

PO Box ______ 911 #_________ Apt. # _______ Postal Code _____________________________

Home Telephone ________________________ Work Telephone _____________________________

Other Telephone ________________________ E-mail Address ____________________________

Occupation ____________________________

Employer ______________________________ Location ___________________________________

Spouse's Name _________________________ Children (names) ____________________________

Contact Name __________________________ Contact Phone ______________________________

Please advise us of any changes made at a later date to the above information

Most Recent Chiropractic Care:

Name _____________________________________ Location _____________________________

Last Visit _________________________________ Results: Excellent Good Fair Poor

Current Medical Doctor/ Nurse Practitioner:

Name _____________________________________ Location _____________________________

You were referred to our office by: ☐friend/ family member _____________________________
NAME

☐phone book ☐walk-in ☐newspaper ☐Medical Doctor ☐Nurse Practitioner ☐Other ________________

I have received treatment for this current problem from:
☐Medical Doctor ☐Hospital
☐Other Chiropractor ☐Massage Therapist
☐Physiotherapist ☐Other

This visit is due to a:
☐Recent Motor Vehicle Accident
☐Work Related Injury (WSIB)

PLEASE ASK US FOR HELP IF YOU HAVE ANY QUESTIONS.

Mount Forest Chiropractic Name: ______________________________

File #: __________ Date: ____________________

COMPLAINT HISTORY

What problem(s) would you like the doctor to address? ______________________________

Explain how your complaint(s) occurred: ☐ No Reason ☐ At Work ☐ Car Accident

____

____

____

____

____

Is your condition... ☐ Worse ☐ Better ☐ Same ☐ Fluctuates

What makes your condition worse? ____________________ better? ____________________

Are you taking medications for this problem? ☐ No ☐ Yes (list) ____________________

Please indicate other medications that you are taking.

☐ Pain Killers ☐ Muscle Relaxants ☐ Arthritis Meds. ☐ Nerve Pills ☐ Blood Pressure Pills ☐ Insulin

☐ Heart Meds. ☐ Birth Control ☐ Estrogen ☐ Vitamins ☐ Blood Thinners ☐ Thyroid Pills

☐ Cholesterol ☐ Other (please list)______________________________

Mark the areas of the body where you feel the described sensations.

Use the appropriate symbols. Include all affected areas.

Stiff/ Tight................X X X X

Dull/ Aching ....A A A A

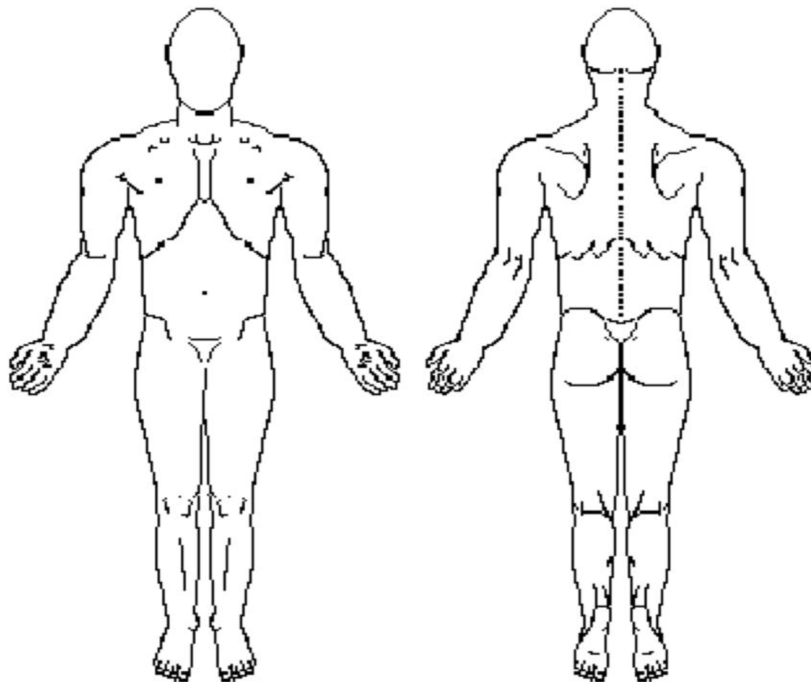
Sharp/ Stabbing....../ / / / / /

Pressure..................> > > >

Pins & Needles/ Tingling ....* * * * *

Numbness..............N N N N

Burning.................O O O O



Mount Forest Chiropractic - 148 Main Street South - Mount Forest, ON N0G 2L0

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Mount Forest Chiropractic Name: ____

File #: ____________ Date: ________________________

Changes/ Limitations in Activities of Daily Living due to your injury:

Sleep:	Self Care:	Sports:	Hobbies:	Care of Children:	Care of Home:
☐ Moving in Bed	☐ Dressing	☐ Exercising	☐ Reading	☐ Lifting child	☐ Vacuum/clean
☐ Getting Settled	☐ Bathing/Showering	☐ Walking	☐ Watching TV	☐ Picking up toys	☐ Dishes/Cooking
☐ General Sleeping	☐ Hair Care	☐ __________	☐ _________	☐ Bathing/Washing child	☐ Lawn/Garden
	☐ Personal Care/Hygiene	☐ _________	☐ _________	☐ General Care	☐ Garbage

Limitations: Check all that apply:

I have difficulty…

☐ Kneeling ☐ Bending ☐ Twisting ☐ Sitting ☐ Standing ☐ Climbing Stairs

☐ Climbing Ladder ☐ Reaching ☐ Walking ☐ Driving ☐ Repetitive Work ☐ Writing

☐ Lifting floor to waist ☐ Lifting waist to shoulder ☐ Keyboarding/Computer use

Car/ vehicle accident(s): ☐ Minor (no medical attention) ☐ Minor (some medical attention/ x-rayed) ☐ Major (injury/ hospitalization)

Surgeries: ☐ Back ☐ Neck ☐ Joint Replacement ☐ Gall Bladder ☐ Appendix ☐ Tonsils ☐ Hernia ☐ Heart ☐ Other

Significant Injuries (Broken bones, sprains, falls): ____

Serious illnesses/ hospitalizations: ____

Childhood Illnesses: ☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rheumatic Fever ☐ Polio ☐ Scarlet Fever ☐ Whooping Cough ☐ Rubella (German Measles) ☐ Other

Other health problems (e.g. Diabetes, arthritis, heart/ stroke): ____

Please list any **X-rays** you have had within the past 5 years: ____

LIFESTYLE

Height ______________ **Weight** ________________

Pregnant ☐ Yes ☐ No Due Date ___________________________

Regular Exercise ☐ Yes ☐ No

☐ Walking ____________(usual distance) ☐ Running ______________ (usual distance)

☐ Sports (please list) ____

Diet ☐ Satisfied with diet ☐ Dissatisfied with diet

Weight ☐ Satisfied with weight ☐ Dissatisfied with weight

Stress ☐ Low ☐ Moderate ☐ High Why high stress? ________________________________

Sleep ☐ Good ☐ Poor Why poor sleep? ________________________________

Intake (Indicate amount)

☐ Coffee _____(cups/ day) ☐ Tea ____ (cups/ day) ☐ Soft Drink (Cola) ____ (cups/day)

☐ Alcohol________________ ☐ Cigarettes _______________ ☐ Soft Drink (non-Cola) _____(cups/day)

If you stopped smoking, when did you stop?________________________

Mount Forest Chiropractic Name: ____

File #: ___________ Date: ______________________

REGULAR ACTIVITY HISTORY

I am....

☐ Full Time ☐ Part Time ☐ Not Working ☐ Retired ☐ Student

DAILY ACTIVITIES (including work, hobbies, etc.):

My daily activities include...

☐ Prolonged Standing ☐ Extensive Walking ☐ Bending / Twisting ☐ Reaching ☐ Repetitive Movements
☐ Heavy Lifting (over 20 lbs) ☐ Telephone Use ☐ Extensive Sitting ☐ Prolonged Driving ☐ Care of Children
☐ Computer Use

My Work is...

☐ Home based ☐ Farm Work ☐ Factory Setting ☐ Trades ☐ Office Setting ☐ Traveling ☐ Retail / Food Services
☐ Other_____________________

My drive to/from work is...

☐ Less than 30 minutes ☐ 1/2 - 1 hour ☐ Over 1 hour ☐ No driving ☐ Walk/Bicycle

The vehicle I typically drive is...

☐ Small Car ☐ Large Car ☐ Bicycle ☐ Horse-drawn vehicle ☐ Van ☐ Truck ☐ Other

OTHER REGULAR ACTIVITIES

☐ Gardening ☐ Sports ☐ Biking ☐ Hiking/Walking ☐ Swimming
☐ Other (please list) ________________ _______________ ________________ ________________

FAMILY HISTORY

Does anyone in your family have (or had) a history of the following? *Please indicate the relationship.*

1. Heart Attack
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

2. Stroke
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

3. High Blood Pressure
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

4. Cancer:(Type) ___________________
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

5 Cancer:(Type) ____________________
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

6. Cancer: (Type) _______________
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

7. Tuberculosis
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

8. Kidney Disease
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

9. Anemia
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

10. Epilepsy
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

11. Alcohol / Drug Addiction
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

12. HIV / AIDS
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

13. Arthritis
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

14. Diabetes
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

15. Scoliosis
☐ Father ☐ Brother/ Sister
☐ Mother ☐ Grandparent

Other (please name) ____

Mount Forest Chiropractic Name: ______________________________

File #: __________ Date: ____________________

PERSONAL HISTORY

Please check any of the following you have had in the past 2 years.

Muscles / Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Hand Trouble
- ❑ Wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Ankle pain
- ❑ Foot Trouble
- ❑ Weakness
- ❑ Swollen joints
- ❑ Painful Tailbone
- ❑ Shoulder pain
- ❑ General stiffness
- ❑ Pain between shoulders
- ❑ Difficulty chewing
- ❑ Clicking jaw
- ❑ Other (please name)

General

- ❑ Headaches
- ❑ Blackouts
- ❑ Dizziness
- ❑ Insomnia
- ❑ Skin problems
- ❑ Rashes
- ❑ Nervousness
- ❑ Sweats
- ❑ Fainting
- ❑ Abnormal weight gain
- ❑ Abnormal weight loss
- ❑ Loss of consciousness
- ❑ Allergies (please list)
- ❑ Depression
- ❑ Anxiety
- ❑ Convulsions

Cardiovascular

- ❑ High blood pressure
- ❑ Angina
- ❑ Poor circulation
- ❑ Heart pain
- ❑ Heart / blood disease
- ❑ Bleeding disorder
- ❑ Hardened arteries
- ❑ Irregular heartbeat
- ❑ Cold/tingling -arms/legs

Digestion

- ❑ Diarrhea
- ❑ Vomiting
- ❑ Poor appetite
- ❑ Nausea
- ❑ Constipation
- ❑ Jaundice
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Food Intolerances
- ❑ Heartburn
- ❑ Gas/bloating after meals
- ❑ Black/bloody stool
- ❑ Colitis
- ❑ Painful bowel movement
- ❑ Weight trouble
- ❑ Cramping
- ❑ Gallbladder problems
- ❑ Liver problems

Respiration

- ❑ Chronic cough
- ❑ Chest pain
- ❑ Spitting/Coughing blood
- ❑ Painful breathing
- ❑ Asthma
- ❑ Difficulty breathing

Genitourinary

- ❑ Trouble urinating
- ❑ Blood in urine
- ❑ Painful urination
- ❑ Bladder infection
- ❑ Bedwetting
- ❑ Kidney infection

MALE

- ❑ Prostate trouble

FEMALE

- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Cramping
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Breast problems

Eyes, Ears, Nose, Throat

- ❑ Speech difficulty
- ❑ Earaches
- ❑ Frequent colds
- ❑ Noises (e.g. ringing) in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Difficulty swallowing
- ❑ Thyroid problems
- ❑ Eye/Vision problems
- ❑ Sore throat
- ❑ Hearing loss
- ❑ Ear infections

Other

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