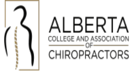

Energy Chiropractic Consultation Admittance Form

Last Name:	First Name:	Gender: M / F
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )

Alberta Health Care #	Third Party Insurance #
Emergency Contact Name:	Emergency Contact Phone ( )

Date of Birth: d/m/y	Age:	Height:	Weight:

Occupation:	Marital Status: Single Married Widowed Divorced

May we contact you by email? (**appointment reminders & payment receipts only**) ☐ Yes ☐ No email address ________________

How did you find out about our clinic? If recommended, please state name. ________________________

Please check all answers and fill in the blanks where appropriate.

Reason(s) for appointment: ____

When did your condition begin? ____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when? ________________

____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur? ________________

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? ____

List all previous surgeries, illnesses, injuries (including MVA): ______________________________

____

____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. ________________ Date: ________________

Family doctor name: Dr. ____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: __________

____

Date: ____________________ Patient signature: ______________________________

Parent/Guardian (if applicable) ______________________________