Kanata Chiropractic Centre Dr. Tony Brunelle & Dr. Marcelle Forget
208 Beaverbrook Road, #208, Kanata, Ontario K2K 1L1 613-592-8537 KanataChiropractic.com

Patient Entrance Form

Date: ________________

Mr., Mrs., Ms., Dr., Other _______

Name:

Address:

City, Province: _____________________________Postal Code:

Home Tel.: ( ) ____________Bus. Tel.: __________Cell. Tel.:

E-mail Address:

Date of Birth (D/M/Y) __________Age: ______Marital Status – S M D W Sep.

Spouse's Name: _____________________Children:

Occupation (Yours) :

Employer: _____________________________Phone Number:

Emergency contact: __________________________ Phone Number:

How did you hear about our office? Friend __ Phone Book __ Sign __ Other

Prior Chiropractic Care:

Name: ________________________________Telephone:

X-rays taken: Yes No Date: ___________________

Results: Excellent Good Fair Poor

Medical Doctor

Name: _______________________________Telephone:
Address:

Date of the last Appointment: __________________Date of Last Physical:

Reason for consulting this office:

Expectations:

Have you ever had any of the following?

Aneurysm __ osteoporosis __ diabetes __ arthritis __ V.D. __
respiratory conditions __ epilepsy __ cancer __ strokes __ allergies __
heart conditions __ hepatitis __ nervous condition __ fatigue __ polio __
sleeping difficulty __ pneumonia __ pleurisy __ asthma __ psoriasis __ HIV __
sinus conditions __

Childhood conditions had, please indicate:

Measles __ mumps __ chicken pox __ whooping cough __ scarlet fever __ diphtheria __
rheumatic fever __ typhoid fever __ ear infections __
tubes in ears __ chronic ill __

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any outstanding balance on my account is due immediately.

Signature: ____

PATIENT PAST HISTORY

HABITS OF LIFESTYLE

When was your last visit to the dentist?

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Purpose of the dental appointment:

Do you smoke: Yes No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals more than 4 meals

Please list the 3 most important stressors in your life: ______________________________
____
____

Falls and accidents – list:

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

If so, for how long:

Have you previously been hospitalized: Yes No

Please list:

Any family health conditions or problems: Yes No

Please list:

Signature: ___________________________________ Date:

PATIENT PAST HISTORY FORM

Name: ___________________________________ Date: __________________

Please check the appropriate circle for any of the following symptoms that you have or have had previously.

O = Occasional F = Frequent C = Constant

O F C

0 0 0 allergy
0 0 0 chills
0 0 0 convulsions

0 0 0 dizziness
0 0 0 fainting
0 0 0 fevers
0 0 0 headaches

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0 0 0 loss of sleep
0 0 0 nervousness
0 0 0 depression
0 0 0 neuralgia
0 0 0 numbness
0 0 0 sweats
0 0 0 loss of weight
0 0 0 tremors

MUSCLE & JOINT
0 0 0 arthritis
0 0 0 bursitis
0 0 0 foot trouble
0 0 0 hernia
0 0 0 low back pain
0 0 0 neck pain
0 0 0 neck stiffness
0 0 0 pain between shoulders

RESPIRATORY
0 0 0 chest pain
0 0 0 chronic cough
0 0 0 difficulty breathing
0 0 0 spitting blood
0 0 0 throat phlegm
0 0 0 wheezing

EYES, EARS, NOSE & THROAT
0 0 0 colds
0 0 0 crossed eyes
0 0 0 deafness
0 0 0 dental decay
0 0 0 asthma
0 0 0 ear aches
0 0 0 ear discharges
0 0 0 ear noises

O F C

0 0 0 sinus infections
0 0 0 enlarged glands
0 0 0 enlarged thyroid
0 0 0 sore throats
0 0 0 tonsillitis

0 0 0 eye pain
0 0 0 failing vision
0 0 0 far sighted
0 0 0 gum trouble
0 0 0 hay fever
0 0 0 hoarseness
0 0 0 nasal obstruction
0 0 0 near sighted
0 0 0 nosebleeds

CARDIO-VASCULAR
0 0 0 rapid heart beats
0 0 0 slow heart beats
0 0 0 swelling of ankle
0 0 0 hardening of arteries
0 0 0 high blood pressure
0 0 0 pain over heart
0 0 0 poor circulation

GASTRO INTESTINAL
0 0 0 excessive hunger
0 0 0 burping or gas
0 0 0 liver trouble
0 0 0 colitis
0 0 0 colon trouble
0 0 0 constipation
0 0 0 diarrhea
0 0 0 difficult digestion
0 0 0 distension of abdomen
0 0 0 stomach pain
0 0 0 gall bladder trouble
0 0 0 hemorrhoids
0 0 0 intestinal worms
0 0 0 jaundice
0 0 0 poor appetite
0 0 0 nausea
0 0 0 vomiting
0 0 0 vomit blood

O F C
SKIN
0 0 0 boils
0 0 0 bruise easily
0 0 0 dryness
0 0 0 hives or allergy
0 0 0 itching
0 0 0 skin rash
0 0 0 varicose veins

GENITO-URINARY
0 0 0 bedding wetting
0 0 0 blood in urine
0 0 0 frequent urination
0 0 0 loss control urine
0 0 0 kidney infection
0 0 0 painful urination
0 0 0 prostate trouble
0 0 0 pus in urine
0 0 0 smell of urine

PAIN OR NUMBNESS IN;
0 0 0 shoulders
0 0 0 arms
0 0 0 hands
0 0 0 hips
0 0 0 legs
0 0 0 knees
0 0 0 ankles
0 0 0 feet
0 0 0 painful tail bone
0 0 0 sciatica
0 0 0 swollen joints

FOR WOMEN ONLY
0 0 0 cramps
0 0 0 heavy flow
0 0 0 light flow
0 0 0 irregular cycle
0 0 0 painful cycle
0 0 0 discharge
0 0 0 sore breasts
Menopausal: yes no
Last menstruation date:
Pregnant: yes no
Due date: __________

CONSULTATION FORM

NAME: ________________________AGE: _____ FEMALE ___ MALE ___ DATE: _____________

A) PRESENTING COMPLAINT B) SECONDARY COMPLAINT C) OTHER CONCERNS

HISTORY, DESCRIPTION AND LOCATION OF THE COMPLAINT (S)

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PREVIOUS HISTORY OF THE COMPLAINT (S) AND PREVIOUS HEALTH HISTORY

WHAT DYSFUNCTION IT IS CAUSING

WHAT AGGRAVATES THE COMPLAINT (S)

WHAT RELIEVES THE COMPLAINT (S)

ANY CURRENT OR PREVIOUS TREATMENT FOR THE COMPLAINT

LIST ANY MEDICATION OR DRUGS YOU ARE CURRENTLY TAKING

SURGERY AND OPERATIONS – LIST

SURGERY RECOMMENDED BUT NOT PERFORMED – LIST

LIST ANY VITAMINS AND MINERALS TAKING CURRENTLY

PAIN SCALE: CAUSE AND FACTORS:
Day 0 - - - - - - - - - -10 A) MVA/accident
Night 0 - - - - - - - - - 10 B) fall/injury
Sitting 0 - - - - - - - - - 10 C) sickness/illness
Standing 0 - - - - - - - - -10 D) unknown
Walking 0 - - - - - - - - -10
Working 0 - - - - - - - - - -10 ONSET
Sleeping 0 - - - - - - - - - 10 i) sudden
ii) slow
iii) gradual

PAIN PROFILE

NAME: ______________________________ DATE: ____________________

- Draw a picture of yourself – (don't worry about the art work, just do your best)
- Draw in your face
- Show area (s) of pain or unusual feeling

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• Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Indicate problem areas as follows **Numbness : ••••••**
Pins and Needles: oooooo **Burning: xxxxxx** **Aching: ******** **Stabbing: //////**

Kanata Holistic Chiropractic Centre
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WE ASK THAT YOU PLEASE DO NOT WEAR PERFUME OR COLOGNE. WE TREAT PATIENTS WHO HAVE SEVERE ALLERGIC REACTIONS TO THESE PRODUCTS. THANK YOU SO MUCH FOR YOUR CO-OPERATION.