

# PATIENT ENTRANCE FORM

Name (Last/First): \_\_\_\_\_ (Male or Female) Date: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

City, Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Work

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Date of Birth(D/M/Y): \_\_\_\_\_ Age \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_

How did you hear about our office:  referral from \_\_\_\_\_  
 newspaper  
 other

***\* If this is a work related injury (WCB), please see the receptionist immediately.***

***\* If this is an Automobile Accident Insurance Claim, please see the receptionist immediately.***

## HEALTH HISTORY:

*It is very important that you give us accurate and complete information about your medical history and condition as treatment or procedures recommended will be based on such information.*

## PRIOR CHIROPRACTIC CARE:

Chiropractor's Name: Dr. \_\_\_\_\_ Town/City: \_\_\_\_\_

X-rays taken:  YES  NO Date: \_\_\_\_\_

## MEDICAL DOCTOR:

Doctor's Name: Dr. \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

**Habits of Lifestyle:**

- Do you smoke:  yes If yes, amount \_\_\_\_\_  no
- Do you consume alcohol:  heavy  moderate  light  none
- Do you exercise:  heavy  moderate  light  none
- Hours slept per night:  4-6  6-8  8-10  12+
- Do you wake rested:  always  usually  seldomly  rarely
- Rate your appetite:  poor  average  excessive
- Rate your diet:  poor  average  exceptional
- Do you eat regularly:  breakfast  lunch  dinner
- Meals eaten per day:  1 meal  2 meals  3 meals  4+
- Daily water consumption:  0-4 cups  4-7 cups  8 or greater cups
- Daily coffee consumption:  0  1-2 cups  3-4 cups  5-6 cups  > 6
- Daily pop consumption:  0  1-2 cans  3-4 cans  5-6 cans  > 6
- List any vitamins, herbal products, or medications: \_\_\_\_\_

Do you think you may need to take vitamins and minerals:  yes  no  not sure

List any prior or scheduled surgeries/operations: \_\_\_\_\_

Have you ever been knocked unconscious:  yes  no

Have you ever been hospitalized:  yes  no

Are you wearing:  custom made orthotics  inner soles  arch supports  heel lifts

**Do you have any of the following:**

- |   |  |   |                                |
|---|--|---|--------------------------------|
| <input type="checkbox"/> allergies        | <input type="checkbox"/> aneurysm            | <input type="checkbox"/> arthritis            | <input type="checkbox"/> other |
| <input type="checkbox"/> cancer           | <input type="checkbox"/> diabetes            | <input type="checkbox"/> epilepsy             |                                |
| <input type="checkbox"/> fatigue          | <input type="checkbox"/> hepatitis           | <input type="checkbox"/> depression           |                                |
| <input type="checkbox"/> osteoporosis     | <input type="checkbox"/> pneumonia           | <input type="checkbox"/> sinus conditions     |                                |
| <input type="checkbox"/> psoriasis        | <input type="checkbox"/> sleeping difficulty | <input type="checkbox"/> fibromyalgia/chronic |                                |
| <input type="checkbox"/> venereal disease | <input type="checkbox"/> HIV/AIDS            | fatigue                                       |                                |

**Please list any family health conditions (siblings, parents, grandparents)**

\_\_\_\_\_

# PATIENT PAST HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously

O = Occasional                      F = Frequent                      C = Constant

**SKIN**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> allergy<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chills<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> convulsions<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> dizziness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fainting<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fevers<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> headaches<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> loss of sleep<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nervousness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> depression<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nasal obstruction<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sweats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sinus infections<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> enlarged glands<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sore throats<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> tonsillitis<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> eye pain<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> failing vision<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> far sighted<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> gum trouble<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hay fever<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hoarseness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> numbness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> boils<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bruise easily<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> dryness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hives or allergy<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> itching<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> skin rash<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> varicose veins<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> loss of weight<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nosebleeds<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> neuralgia<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> near sighted |
|---|--|---|

**GENITO-URINARY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bed wetting<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> loss of urine control<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> prostate trouble | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> blood in urine<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kidney infection<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> pus in urine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> frequent urination<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> painful urination<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> smell of urine |
|---|---|--|

**MUSCLE & JOINT**

- |   |  |
|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> tremors<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> arthritis<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bursitis<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> foot trouble<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hernia<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> low back pain<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> neck pain<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> neck stiffness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> pain between shoulders | <p><b>CARDIO-VASCULAR</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> rapid heart beat<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> slow heart beat<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> swelling of ankles<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hardening of arteries<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> high blood pressure<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> low blood pressure<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> pain over heart<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor circulation |
|---|--|

**PAIN OR NUMBNESS**

- |   |
|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> shoulders<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> arms<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hands<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hips<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> legs<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> knees<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ankles<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> feet<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> painful tail bone<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sciatica<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> swollen joints |
|---|

**RESPIRATORY**

- |  |
|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chest pain<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> wheezing<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chronic cough<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> difficulty breathing<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> spitting blood<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> throat phlegm |
|--|

**GASTRO INTESTINAL**

- |  |
|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> vomiting<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> vomit blood<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nausea<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> excessive hunger<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> burping or gas<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> liver trouble<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> colitis<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> colon trouble<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> constipation<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> diarrhea<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> difficult digestion<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> distention of abdomen<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> stomach pain<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> gall bladder trouble<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hemorrhoids<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> intestinal worms<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> jaundice<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor appetite |
|--|

**FOR WOMEN ONLY**

- |  |
|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cramps<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> heavy flow<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> light flow<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> irregular cycle<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> painful cycle<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> discharge<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sore breasts<br>Menopausal: <input type="checkbox"/> yes <input type="checkbox"/> no<br>Pregnant: <input type="checkbox"/> yes <input type="checkbox"/> no<br>due date _____ |
|--|

**EYES, EARS, NOSE & THROAT**

- |   |
|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> colds<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> crossed eyes<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ear aches<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ear discharges<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ear noises<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> deafness<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> dental decay |
|---|

Name \_\_\_\_\_

State your reason for consulting our office again

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Expectations: Which stage of care are you hoping to achieve?

- |  |  |
|--|--|
| <input type="checkbox"/> Pain & Symptom Relief                     | <input type="checkbox"/> Corrective Care (correct cause of pain) |
| <input type="checkbox"/> Wellness Care (optimize health potential) |  |
| <input type="checkbox"/> Other                                     |  |

Show area(s) of pain or unusual feeling.

Circle the affected areas on this body and use the appropriate symbols to describe the sensations you are feeling. Mark areas of radiation. Include all affected areas.

**Burning**

Mark with, *X*

**Aching**

Mark with, *A*

**Stiffness**

Mark with, *S*

**Dull Pain**

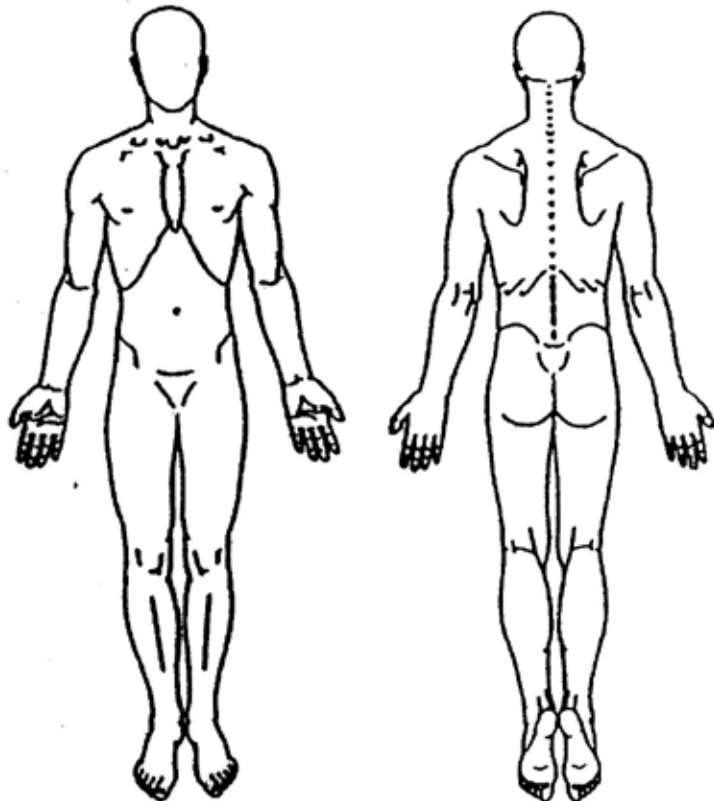
Mark with, *D*

**Sharp / Stabbing Pain**

Mark with, *P*

**Numbness / Pins or Needles**

Mark with, *N*



**Darrel J. Kopala D.C., B.Sc. Pharm.**  
**Cold Lake Chiropractic & Wellness Centre**

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594-WELL (780) 594-9355

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**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment, and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

I give consent to have my and/or my family's picture and/or name used in Dr. Kopala's Wellness Centre. This consent would be for the purpose of thank-you recognition and/or in office advertisements.

\*\*\*\*\*

Dated This \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Patient Signature (Legal Guardian)

\_\_\_\_\_  
Witness of Signature

\_\_\_\_\_  
Patient (Please Print)

\_\_\_\_\_  
Witness (Please Print)