Patient Admittance Form

Mah Chiropractic Clinic
7222 Edgemont Blvd. N.W.
Edgemont Athletic Club
Calgary, AB. T3A 2X7
Phone: (403) 241-1886
Fax: (403) 241-0995

Name:_____
(Family) (First) (Initial)

Sex: □Male □ Female

Date of Birth: _____Age: _____Height: _____Weight: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Email Address: _____

Alberta Health Care Number: _____

Your Occupation: _____

In Case of an Emergency, who should we notify / phone: _____

Have you received prior chiropractic care? Doctor's Name: _____

Family Doctor's Name: _____ Consent to Contact? _____

What is your Chief Complaint? _____

Is this an auto accident case, or have you recently been in an accident? □ Yes □ No

Is this a workman's compensation case? □ Yes □ No

Have you seen any other physician or health care practitioner for this complaint? □ Yes □ No

Information collected by Mah Chiropractic clinic is used in our office to ensure appropriate assessment and treatment services can be provided and billed accordingly. The information is collected under the authority of The Health Information Act, for more information please speak with our privacy officer, Dr. Mah.

If this is an auto accident case, I understand that I am responsible for all debts incurred at this clinic, and that these are due payable within 10 days of a court or out of court settlement.

- **Cancellation Policy: 24 hours notice is required. Otherwise your account will be charged for your missed appointment. _____ ← please initial**

Date: _____ **Signature:** _____

General Systems Review

Neck Respiratory

- Allergies
- Asthma
- Bronchitis
- Chest Pain
- ChronicCough
- Emphysema
- Frequent Colds
- Hay Fever
- Pneumonia
- Smoker

Skin

- Acne
- Boils
- Dermatitis
- Eczema
- Fungal infection
- Dryness
- Herpetic Infection
- Itching
- Psoriasis
- Rashes
- Scars

Vision

- Redness
- Glaucoma
- Light Sensitivity
- Blurred Vision
- Cataracts
- Double Vision

Cardiovascular

- Angina
- Arrhythmia's
- Arteriosclerosis
- Blood Clots
- Chest pain
- Cold / Blue hands/feet
- Low Blood Pressure
- High Blood Pressure
- Noticed heart racing
- Shortness of Breath
- Pounding Sensation
- Heart Attack
- CHF

Vascular

- Anemia
- Frequently Bleeding nose
- Easy Bruising
- Leg pain after walking
- Raynauld's
- Swelling
- Thromophlebitis
- Varicose Veins

Hair

Ears

- Buzzing
- Discharges
- Infections
- Ringing
- Dizzy

Head

- ADD/ADHD
- Concussion
- Headaches
- Insomnia
- Learning Problems
- Memory Decline
- Mental Illness

Circle Hours of sleep per night
2-4 4-6 6-8 8-10 12+

Mouth Throat

- Bleeding
- Gum Disease
- Pyorrhea
- Halitosis
- Sore Throat

Gastro – Intestinal

- Digestive Disorders
- Gall Bladder Problem
- Gas and Bloating
- Irritable Bowel Syndrome
- Pain after eating
- Poor appetite
- Can not gain weight
- Alternating diarrhea & Constipation
- Black Stool
- Blood in Stool
- Mucous in stools
- Constipation
- Diarrhea
- Chron's
- Colitis
- Heart Burn
- Nausea

Gastro-Intestinal (continued)

- Vomiting
- Ulcers

Urinary

- Bed Wetting
- Bladder / Kidney infections
- Blood in Urine
- Burning
- Dribbling
- Hesitancy
- Incontinence
- Infections
- Kidney Stones
- Yeast Infection
- Decreased Frequency
- Increased Frequency
- Decreased Force

Musculoskeletal

- Disc problems
- Fractures
- Low Back Pain
- Upper Back Pain
- Neck Pain
- Gout
- Hernia
- Muscle cramps
- Musclestrain
- Stiffness
- Numbness
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Scoliosis
- Fibromyalgia
- Chronic Fatigue

Neurological

- Alzheimer's
- Epilepsy
- Fainting
- Numbness
- Parkinson's
- Seizures
- Tremors

Endocrine

- Diabetic
- Hyperthyroid
- Hypothyroid
- Increased Thirst
- Water Retention
- Cold Intolerance

Female Reproductive

- Pregnant Yes No
- Due date _____
- Birth Control Pills
- Discharges
- Hysterectomy
- Lumps
- Menopause
- PMS
- Regular Period
- Sores
- Bleeding Between Periods
- Decreased Sex Drive
- Fertility Problems
- Frequent Periods
- Increase Menstrual Flow
- Painful cycle
- Pelvic Inflammation
- STD

Male Reproductive

- Impotence
- Pus Discharge
- Rashes
- Testicular Pain
- Decreased Sex Drive
- Prostate Problems
- Trouble with Urination

Other

- Alcoholic
- Cancer
- Chemotherapy
- Depression
- Hepatitis
- Night sweats
- Steroid Therapy
- Weight Problems
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Radiation Therapy

Treatment History

What type of practitioners have you seen for this condition? Please rate the effectiveness of these treatments

1 = Poor 5 = Good

Chiropractic 1 2 3 4 5
Physiotherapy 1 2 3 4 5
Medical Doctor 1 2 3 4 5
Naturopath 1 2 3 4 5
Massage Therapist 1 2 3 45
Other 1 2 3 4 5
Surgeries – Dates _____

_____

Family History

- Arthritis
- Genetic Problems
- Auto Immune Condition
- Cancer
- High Blood Pressure
- Diabetes
- High Cholesterol
- Hypothyroidism
- Hyperthyroidism
- Heart Attack
- Stroke
- Vascular Problems

Childhood Conditions

Please check the conditions that you have had:

- Measles
- Mumps
- Chicken Pox
- Whooping cough
- Scarlet Fever
- Diphtheria
- Rheumatic Fever
- Typhoid Fever
- Ear infections
- Tubes in Ears
- Chronic Ill
- Asthma
- Allergies

What other information do you feel we should be aware of:

What are you looking for at our clinic…? Help me – Help you!

It is very important to us that your experience at our clinic is a good one. Because of this we need to ask you a few more questions.

1. **What results would you like to achieve by coming to our clinic?**

2. **Do you have a concern with the therapy that you would like to address before commencement of treatment (adjustments, changing clothes, previous experiences, office policies etc.)?**

3. **Is there a particular Technique / Therapy that you are would like us to use in your case?**

- ☐ I would like the doctor to decide what the most appropriate technique is for my condition.
- ☐ Active Release Technique – Soft Tissue Management System
- ☐ Modified Diversified (Manual adjusting by hand) / Activator Methods
- ☐ Acupuncture – Traditional Chinese Medicine (TCM)
- ☐ Detoxifications Program
- ☐ Meridian Therapy / BIOSET / TCM
- ☐ Exercise rehabilitation protocols – Strength and Rehabilitation with the WHC Trainers

4. **Are there any other issues you would like to address?**