Chiropractic Wellness Centre
Dr. Imran Dharshi
Box 1103, 281 Centre Street
Drumheller, AB T0J 0Y0
403-823-3020

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:	Age:	Height:	Weight:
Occupation:		Marital Status: Single Married Widowed Divorced	

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.: _____

_____

_____

Missed appointments are an inconvenience not only to us, but also for other patients who many have wanted your appointment time. If you do not call to inform us that you cannot keep your scheduled appointment you will be billed.

I understand that my Supplemental Health Care coverage for chiropractic care represents only a portion of the Doctor's fee and that I am personally responsible for the balance of that fee.

Date: _____ Patient signature: _____

Chiropractic Wellness Centre Dr. Imran Dharshi Box 1103, 281 Centre Street, Drumheller, AB T0J 0Y0

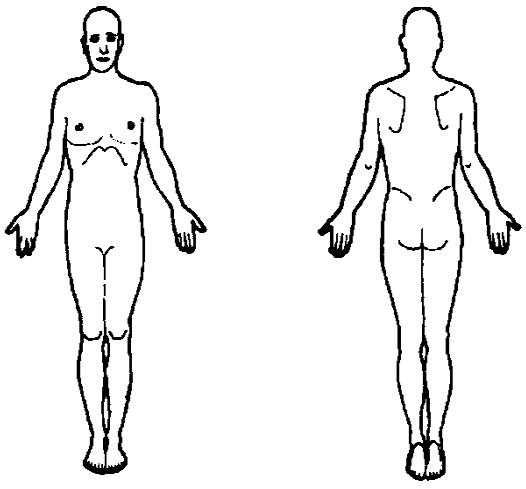
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------- Yes No
2. Hardening of the arteries (arteriosclerosis)---------- Yes No
3. Diabetes ---------- Yes No
4. Tuberculosis ---------- Yes No
5. Cancer---------- Yes No
   Where? _____
6. Heart or blood diseases---------- Yes No
7. Bone spurs on the neck bones (cervical sprain) ---------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From _____ to _____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision) ---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
14. Slurred speech or other speech problems ---------- Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------- Yes No
19. Sudden collapse without loss of consciousness ---------- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain