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	

Email _____

I hereby give consent to Dr. Debbie Wong and AHI to contact me through email, SMS or text messaging for clinic purposes and health matters only.

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: _____