UNIVERSITY OF CALGARY

Student Wellness Services

Health Services
403.210.9355
MacEwan Student Centre, Room 370
2500 University Drive NW
Calgary, AB, Canada T2N 1N4
ucalgary.ca/wellnesscentre

Chiropractic Consultation Admittance Form

Last Name:	First Name:	Middle Initial:
Birth: (D/M/Y)	Age:	Gender: M / F / Other
Address:		Postal Code:
Phone (*Home*) ( )	Phone (Work) ( )	Phone (Cell) ( )
Permanent Address (if other than above):		

UCID#:	Alberta Health Care # (Or Other Provincial #)
Emergency Contact Name:	Do you have Alberta Blue Cross? ☐ Yes ☐ No
Emergency Contact Phone:	Is your spouse 65 or older? ☐ Yes ☐ No *If yes, please let us know so we can direct bill your plan.*
If you're a UCalgary student: Undergraduate ☐ Graduate ☐ Visiting Student ☐	If you're a UCalgary employee: Support Staff ☐ MaPs ☐ Faculty ☐ PostDoc ☐ SU ☐ GSA ☐ Other ☐
Is this a referral from an MD? Yes ☐ No ☐ Doctor's Name: ____________________	Your Dept/Faculty:
Your email:	Your occupation:

Please check all answers and fill in the blanks where appropriate.

Have you been to a chiropractor before? ☐ Yes ☐ No For what condition? ____________________

Chiropractor's name? Dr. ____________________ How long since your last visit? ____________________

Is this a work related injury (WCB)? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No Date of accident: ____________________

If a Motor Vehicle Accident, have you contacted your insurance company? ☐ Yes ☐ No

If an MVA, have you had an assessment/treatment with another health care practitioner ☐ Yes ☐ No

Reason(s) for today's appointment: ____________________

When did your condition begin? ____________________

What is the cause of your problem? ____________________

What makes the pain better? ____________________

What makes the pain worse? ____________________

Indicate the intensity of your pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

PLEASE TURN PAGE OVER

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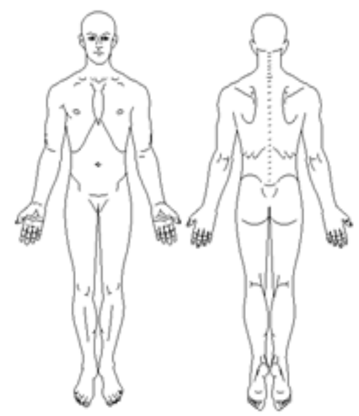
Please circle the location of your pain and describe:



Have you had treatment for this current condition? ☐ Yes ☐ No, If Yes, what: ________________________________

Have you ever had similar problems? ☐ Yes ☐ No, If Yes, when: ____

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests? When? __________________

____

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): ____________________________________

____

____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: __________

____

____

Family health history for mom, dad, siblings, children (many health problems are a result of hereditary spinal weakness and have a tendency to occur in families): ____

____

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act and/or Health information Act. It is required to provide health service. This information will form part of your chiropractic/medical/clinical file. If you have any further questions please contact the Privacy Officer at (403) 210-8904.

Date: __________________________ **Patient signature:** ____

Dr. Initial: _______

Revised 2018/11/13