MRVFC Admittance Form

Last Name:	First Name:	Gender:	
Address:	City, Province:	Postal Code:	
Phone (Cell) ( )	Phone (Work) ( )	Phone (Home) ( )	
Alberta Health Care #		Do you have a third-party insurance?	
Emergency Contact Name:		Emergency Contact Phone ( )	
Date of Birth (m/d/y):	Age:	Height:	Weight (lbs):
Occupation:		Who referred you to our office?	
Email address:		(Email will be used for appointment reminders, receipts, birthday emails, etc.)	

Health Profile

Welcome to Mount Royal Village Family Chiropractic. Our goals are, first, to address the health concerns that brought you to this office, second, to offer you the opportunity to improve your overall health potential and well-being, and third, to answer any questions that you might have. Answering the following questions will give us a health profile allowing us to better assess your condition and help us address your current needs.

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.: _____

_____

Chiropractic Case History

1	**CHIEF COMPLAINT** (include symptoms)	
2	**HISTORY of CONDITION** (mode of onset, course, prior treatment, prior occurrence)	
3	**FREQUENCY**	
4	**INTENSITY**	**VAS Pain Intensity Scale** 1 2 3 4 5 6 7 8 9 10 Least Worst
5	**CHARACTER** (Dull, Sharp, Aching)	
6	**DURATION**	
7	**AGGRAVATING FACTORS**	
8	**RELIEVING FACTORS**	
9	**ASSOCIATED SYMPTOMS** (pain radiations, nausea, etc.)	
10	**SYSTEMS REVIEW**	See page 3
11	**MEDICAL HISTORY** (past illness, surgeries, past injuries, etc.)	
12	**RELATED FAMILY HISTORY**	
13	**PSYCHO-SOCIAL HISTORY**	
14	**MEDICATIONS, DRUGS, VITAMINS, SUPPLEMENTS** (past & present)	
15	**RECREATIONAL or OCCUPATIONAL FACTORS** (e.g., sports, computer work, heavy lifting, etc.)	
16	**SECONDARY COMPLAINTS**	
17a	**X-RAY REPORT** (narrative, have you had xrays?)	
17b	**IMPRESSION** (summary of x-ray report)	

Systems Review

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		

NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis

EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other:

Childhood & Young Adult Years

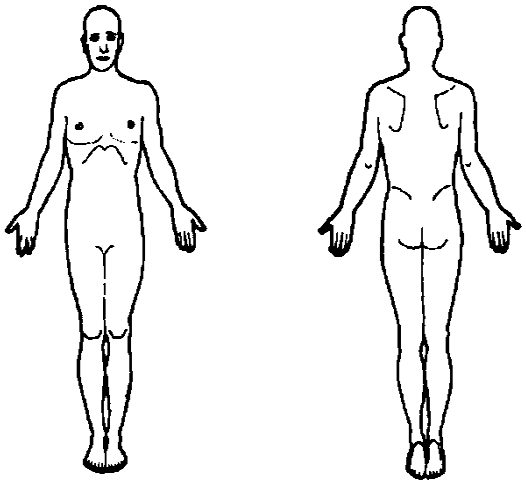
	Y	N
Was your birth C-section, suction or forceps?	☐	☐
Did you have any serious childhood illnesses?	☐	☐
Did you experience any sports injuries as a child or young adult?	☐	☐
Were you spanked or swatted as a child?	☐	☐
Any childhood falls or accidents? (car, crib, tree, bike, bed….)	☐	☐
Was there any prolonged use of medications such as antibiotics, inhalers, Ritalin?	☐	☐
Did you suffer any emotional trauma or significant loss as a child?	☐	☐
Were you checked for traumatic birth syndrome?	☐	☐

Health History Questionnaire

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

Financial/Insurance

In most cases, we can direct bill your insurance plan. For charges in excess of your insurance, we will charge your credit card on file or may pre-pay by debit or cash monthly. By filling out this information, you are giving Mount Royal Village Family Chiropractic to bill your insurance on your behalf.

Insurance Company Name: _____

Member ID Number: _____ Group or Policy Number: _____

If this plan is the plan of a family member or person other than yourself (i.e.: spouse, parent), please provide the plan holder's/Insured Member's full name and birthdate:

Chiropractic Maximums per year: $_____ Per Visit: $ _____ or _____%

Massage Maximums per year: $_____ Per Visit: $ _____ or _____%

Acupuncture Maximums per year: $_____ Per Visit: $ _____ or _____%

Flex Spending Amount (if applicable): $_____ Per Visit: $ _____ or _____ %

What month do your benefits refresh? _____

I accept the terms and conditions Benefit assignment form I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided. I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment. I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the healthcare provider. I accept the terms and conditions Date Signature of plan member.

Signature:_____ Date:_____

The information made on this form (pages 1-5) is accurate and I agree to allow this office to examine me for further evaluation.

Signature:_____ Date:_____

Mount Royal Village
FamilyChiropractic
Acupuncture & Massage