Dr. Thomas Hnatko

PATIENT ADMITTANCE RECORD

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR COOPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS. PLEASE PRINT - THANK YOU

DATE: _____ **Email:** _____

PERSONAL: **Provincial Health Care #:**_____

Name _____ **Male**____ **Female**____ **Phone**_____ **Cell #:**_____

Home address _____ City_____ Province____ Postal Code _____

Date of birth: Month_____ Day_____ Year_____ Height_____ Weight_____

Occupation_____ Employer_____ Work Phone_____

Name of Spouse_____ Number of children_____

(If patient is under 18 years of age, please give parent(s) name(s): _____)

Did someone refer you to our office? _____yes _____no If so, who may we thank?_____

Name of medical doctor_____

Is this a Workers' Compensation case? ____yes ____no Is this an injury from a Motor Vehicle Accident? ___yes ___no

What brings you to our office today?_____

CHIROPRACTIC INFORMATION: (If you have no joint symptoms or complaints and are here for Wellness Services only, please skip to "General Health Information" on page 2.)

Please list your health concerns according to severity	Rate of severity 1 = mild 10 = worst possible	When did this episode start?	If you have had this before, when?	Did the problem begin with an injury?	% of time the pain is present	Is pain Dull? = D Or Sharp?= S
1.	/10			Y / N	/100%	
2.	/10			Y / N	/100%	
3.	/10			Y / N	/100%	
4.	/10			Y / N	/100%	

Does the pain radiate anywhere? ___yes ____no If so, where? _____

Since the problem started is it: About the same? _____ Getting better? _____ Getting worse? _____

Which activities aggravate your condition? _____

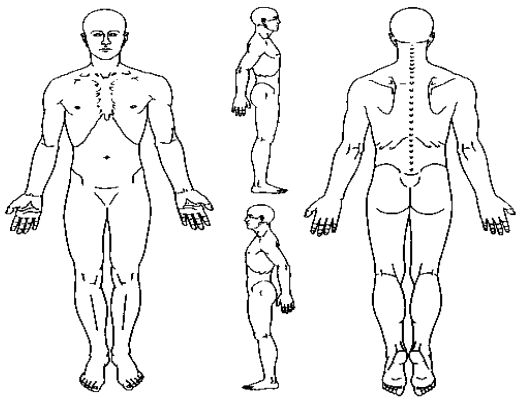
Does anything make it better? _____

Is this condition interfering with any of the following: Work_____ Sleep _____ Daily routine _____ Sports _____

Have you had previous chiropractic care? ____yes ____no Doctor's Name? _____

Indicate the location of the pain by marking the appropriate area on the picture to the right with the following symbols:

Burning - X
Aching - A
Stiffness - S
Dull Pain - D
Sharp/stabbing pain - P
Numbness/pins and needles - N



GENERAL HEALTH INFORMATION:

Are you currently seeing a medical specialist? ____ yes ____no For what? _____

List surgeries / year: 1._____/_____ 2._____/_____ 3._____/_____

Are you currently taking any medications or vitamins? ____yes ____no If so, which ones? _____

_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems) - type / year:

1._____/_____ 2._____/_____ 3. _____/_____

Have you ever had x-rays taken? _____ When?_____ Where?_____

Do you wear orthotics or heel lifts? _____Yes _____No

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes___ No____ Maybe ____
If dietary changes are indicated would you be willing to make changes in your diet?	Yes___ No____ Maybe_____
Would you take whole food supplements if indicated?	Yes___ No____ Maybe _____
If specific exercises or stretching would help, would you consider adding them to your program?	Yes____ No____ Maybe_____

How do you grade your physical health?

Excellent_____ Good _____ Fair _____ Poor _____ Getting better _____ Getting worse_____

How do you grade your emotional/mental health?

Excellent_____ Good_____ Fair_____ Poor_____ Getting better_____ Getting worse_____

FAMILY MEDICAL HEALTH INFORMATION:

Do you or an immediate family member have the history of any of the following:

_ AIDS	_Alcoholism	_ Allergies	_ Arthritis	_ Asthma
_ Bed Wetting	_ Cancer	_ Heart Disease	_ Depression	_ Diabetes
_ Epilepsy	_Hyperactivity	_ Learning Disability	_Low Back Pain	_Multiple Sclerosis
_ Schizophrenia	_ Stomach Ulcers	_Venereal Disease	_ Other _____	

PERSONAL MEDICAL HEALTH INFORMATION:

The following list of conditions may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please mark which of the following <u>you personally</u> have had.

_Appendicitis	_ Malaria	_ Chicken Pox	_ Alcoholism
_ Scarlet Fever	_ Tuberculosis	_ Diabetes	_ Venereal Disease
_Small Pox	_ Whooping Cough	_ Cancer	_ Arthritis
_Hardening of Arteries	_ Anemia	_ Heart Disease	_ Epilepsy
_Pneumonia	_ Measles	_Goiter	_ Mental Disorder
_ Bone spurs	_ Mumps	_ Dizziness	_ Low Back Pain
_ Polio	_ Rheumatic Fever	_ Whiplash	_ Eczema

Please check any of the following you have had within the **PAST 6 MONTHS**:

MUSCULO-SKELETAL

- ❑ Low back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm pain
- ❑ Joint pain/stiffness
- ❑ Walking problems
- ❑ Problems chewing/clicking jaw

NERVOUS SYSTEM

- ❑ Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Fainting/Sudden collapse
- ❑ Convulsions
- ❑ Cold/tingling extremities
- ❑ Visual disturbances (blurring, loss, double)

GENERAL

- ❑ Allergies
- ❑ Loss of sleep
- ❑ Fever
- ❑ Headaches
- ❑ Mood swings
- ❑ Slurred speech

GASTROINTESTINAL

- ❑ Poor-excessive thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gas/bloating after meals
- ❑ Heartburn
- ❑ Black/bloody stool
- ❑ Colitis

GENITO-URINARY

- ❑ Bladder trouble
- ❑ Painful/excessive urination
- ❑ Discolored urine

CVR

- ❑ Chest pain
- ❑ Short breath
- ❑ Blood pressure problems
- ❑ Irregular heartbeat
- ❑ Heart problems
- ❑ Lung problems/congestion
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Loss of consciousness/blackout
- ❑ Stroke

EENT CODE

- ❑ Vision problems
- ❑ Dental problems
- ❑ Sore throat
- ❑ Earaches
- ❑ Hearing difficulties
- ❑ Stuffed nose/sinus problems

MALE/FEMALE CODE

- ❑ Menstrual irregularities
- ❑ Menstrual cramping
- ❑ Vaginal pain/infections
- ❑ Breast pain/lumps
- ❑ Prostate/sexual dysfunction
- ❑ Genital herpes
- ❑

FEMALES:

Are you pregnant? __yes ___no

Menopausal? __yes ___no

Date of last period _____

STRESSORS:

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a._____
   b. _____
   c. _____

2. Biochemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, mold, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological and mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____