UNION WELLNESS CENTRE **Dr. Graham Dinkel D.C.**
100-130 Regina St S., Waterloo, Ontario, N2J 4P9 (519) 725-2275

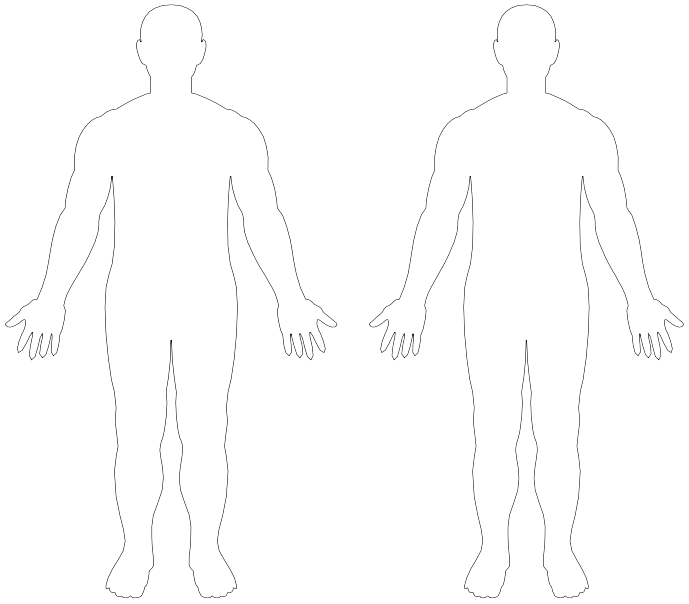
Patient Entrance Form

Patient Number:_____
Name: _____ Date:_____
Mailing Address:_____ Postal Code:_____
Phone Number Residence: _____ Daytime Phone Number:_____
Email address: _____ May we leave message or mailing Y / N
Date of Birth & Age: _____
Occupation/ Employer:_____
Medical Doctor: _____ Referred By:_____
Previous Chiropractor: _____ Gender: M / F

Explain Your Current Complaint: _____
_____
Do you wish to have your area of complaint x-rayed? Y / N
List Other Health Concerns:_____
List Medications/ Dose: _____
List Hospitalizations/ Surgeries/ Traumas _____
_____
How long have you had this condition? _____
Have you had this or a similar condition in the past? yes no
If yes, when: _____\
Is this condition getting progressively worse? yes no
What aggravates your condition? _____
What makes it feel better? _____
Have you consulted others regarding this condition? yes no
List other health complaints. _____
_____

Kindly complete the Symptom Diagram below using the following symbols:

Numbness	??????
Burning	/////////
Pins & Needles	……..
Sharp & Stabbing	XXXX
Dull & Achy	+++++
Stiff & Tight	22222
Weakness	wwww



Front Back

PLEASE TURN OVER AND COMPLETE THE OPPOSITE SIDE:

Pain Scale: Please circle the number to correspond with your level of discomfort.

Day	1	2	3	4	5	6	7	8	9	10
Night	1	2	3	4	5	6	7	8	9	10
Sitting	1	2	3	4	5	6	7	8	9	10
Standing	1	2	3	4	5	6	7	8	9	10
Walking	1	2	3	4	5	6	7	8	9	10
Sleeping	1	2	3	4	5	6	7	8	9	10

Health History Information

Have you suffered from, or has anyone in your family suffered from any of the following? Please circle yes or no. State the family relationship to you. Many health problems are the result of hereditary weakness. This information about you immediate family will give us a better picture of your total health.

Headaches / Migraines	yes	no	Family: _____
High / low blood pressure	yes	no	Family: _____
Menstrual / PMS symptoms	yes	no	Family: _____
Arthritis	yes	no	Family: _____
Muscle cramps	yes	no	Family: _____
Diabetes	yes	no	Family: _____
Heart Disease / stroke	yes	no	Family: _____
Cancer	yes	no	Family: _____
Thyroid (hypo/hyper)	yes	no	Family: _____
Hepatitis / AIDS	yes	no	Family: _____
Alcoholism / drug addiction	yes	no	Family: _____
Allergies / Asthma	yes	no	Family: _____
Epilepsy / Multiple Sclerosis	yes	no	Family: _____
Constipation / Diarrhea / Ulcers	yes	no	Family: _____
Frequent Colds / Flu	yes	no	Family: _____

Please list any Major surgeries or illnesses you have had and when:

_____
_____
_____

Please list any scars you have from trauma or surgery:

_____
_____
_____

Please list any current supplements:

_____
_____
_____

Please circle yes or no to the following questions.

Do you wear special devices in your shoes?	yes	no
Do you suffer (at present) from any of the following?		
Fainting spells / Dizziness	yes	no
Pain that awakens you at night	yes	no

Fevers yes no
Night sweats yes no
Unexplained weight loss yes no
General tiredness / fatigue yes no
Chills yes no
Difficulty sleeping yes no

Have you broken or fractured any bones? yes no
Please list: _____

Have you ever been in an auto accident? yes no
If yes, please give the approximate year. _____
Have you had any other personal injuries or accidents? yes no
If yes, describe: _____
This injury / accident happened in the past year, within the last 5 years or over 5 years. _____

Have you had previous chiropractic care? yes no
Chiropractor: _____
When were you last treated: _____
Were x-rays taken? yes no
Date: _____

Have you had previous massage therapy? yes no

Have you had previous Naturopathic care? yes no

Are you Pregnant? yes no

If stretches or exercises could speed up recovery or prevent reoccurrence, would you be interested?
yes no

Doctor's Signature: _____

Patient's Signature: _____

Guardian's Signature: _____