Dr. Mary-Irene Parker

"committed to achieving excellence"

CHIROPRACTOR

Dr Mary-Irene Parker
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PATIENT ENTRANCE FORM

Name _____ Date of Birth (Day/Month/Year) _____

Address _____ Age _____ Sex: Male ____ Female _____

_____ Occupation _____

Postal Code _____ Employer _____

Email _____ Employer's Address _____

Contact Numbers: _____

Home # _____ Marital Status _____

Work # _____ Name of Spouse/Partner _____

Cell # _____ Number of Children _____

Name of Alternate Contact and Phone #_____

How did you hear about this office? _____

Health Insurance Company/Providers Name_____

Insurance Policy # _____ ID # _____

Claim will be made against:

Recent motor vehicle accident Yes No (if yes, please notify Dr. Parker)
Work related accident/injury Yes No (if yes, please notify Dr. Parker)

Reason for consulting this office:

Presenting complaint (what hurts) _____

_____

_____

Expectations _____

Prior Chiropractic Care:

Name of Chiropractor _____ Telephone _____

Reason for visit: this complaint? Yes No
If no, please state the complaint _____

Results: Excellent Good Fair Poor

To download this form again please visit: www.parrsborobackcare.com

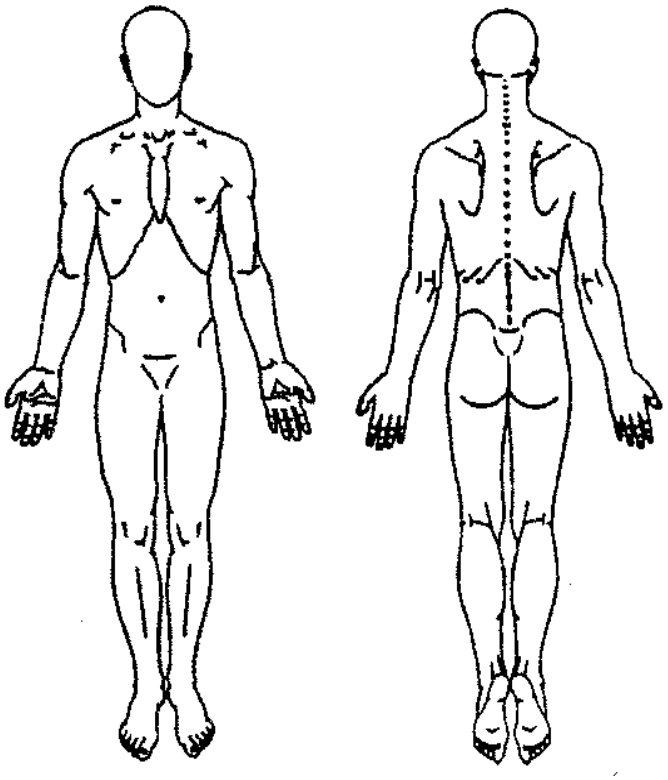
Medical Doctor:

Name of family physician _____ Telephone _____
Have you seen your M.D. regarding today's complaint? Yes No
Date of last appointment _____ Date of last physical _____
X-rays taken? Yes No Date _____

Draw In Your Face

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

PAIN	Circle area
NUMBNESS	^^^^^^^^^^
PINS & NEEDLES	000000000
BURNING	xxxxxxxxxx
ACHING	* * * * *
STABBING	/ / / / / / /
TIGHTNESS	#########



Have you ever had any of the following?

- ❑ aneurysm
- ❑ osteoporosis
- ❑ diabetes
- ❑ arthritis
- ❑ respiratory conditions
- ❑ epilepsy
- ❑ cancer
- ❑ stroke(s)
- ❑ allergies
- ❑ heart conditions
- ❑ hepatitis
- ❑ nervousness
- ❑ anxiety
- ❑ fatigue
- ❑ polio
- ❑ sleeping difficulty
- ❑ pneumonia
- ❑ pleurisy
- ❑ asthma
- ❑ V.D.
- ❑ psoriasis
- ❑ HIV
- ❑ sinus condition

Please check any childhood conditions

- ❑ measles
- ❑ scarlet fever
- ❑ ear infections
- ❑ mumps
- ❑ diphtheria
- ❑ tubes in ears
- ❑ chicken pox
- ❑ rheumatic fever
- ❑ chronic illness
- ❑ whooping cough
- ❑ typhoid fever

Habits of Lifestyle

Do you smoke? Yes No Do you consume alcohol? Yes No

If so, how much? _____ If so, how much? _____

Do you exercise Yes No Exercise – indoor activities _____

Exercise – outdoor activities _____

Rate your sleep hours per night		4-6	6-8	8-10	12+
Do you wake rested?	Yes No				
Rate your appetite	poor	fair	medium	good	excellent
Rate your diet	poor	fair	medium	good	excellent
Do you eat regularly?	Breakfast	Lunch	Dinner		
Do you eat per day?	1 meal	2 meals	3 meals	4 meals	5+ meals

Date of last dental examination _____

List any falls or accidents (including childhood) _____

_____

List any surgery or operations _____

List any surgery suggested but not performed _____

Have you ever been knocked unconscious? Yes No Don't Know

If so, for how long?_____

Do you take vitamins or minerals? Yes No List: _____

List any medications or drugs you are currently taking and the reason for each: _____

_____

_____

Have you previously been hospitalized? Yes No

If so, why were you hospitalized? _____

Any family health conditions or problems? Yes No

Please list: _____

_____

_____

Signature _____ Date _____