OSGOODE CHIROPRACTIC CLINIC
Jennifer J. Bergin D.C.
Angelo David, D.C.
613-826-2527

PATIENT ENTRANCE FORM

Name: _____ **Date:** _____

Address: _____

City, Province: _____ **Postal Code:** _____

Home Tel: _____ **Bus. Tel:** _____ **Cell:** _____

Email: _____

DOB: (D/MY/Y): _____ **Age:** _____ **Marital Status: S/M/D/W/S**

Spouse's Name: _____ **Children:** _____

Occupation (Your): _____

Employer: _____ **Phone :** _____

Address: _____

City, Province: _____ **Postal Code:** _____

Closest Relative: _____ **Phone:** _____

_____ _____

Extended Health Care Company: _____

How did you hear about our office: friend ☐ **phone book** ☐ **sign** ☐ **Other:** _____

Claim will be made against:

1. Recent motor vehicle accident: **Yes** **No** **(If Yes, see attached)**
2. Work related injury/accident: **Yes** **No** **(If Yes, See attached)**

Prior Chiropractic Care:

Name: _____ **Phone:** _____

X-Rays taken: **Yes** **No** **Date:** _____

Results: **Excellent** **Good** **Fair** **Poor**

Medical Doctor:

Name: _____ **Phone:** _____

Address: _____

Date of last appointment: _____ **Date of last physical:** _____

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Jennifer J. Bergin D.C.
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3207 Vance St.
Osgoode, Ontario
K0A 2W0
Tel: 613-826-2527
Fax: 613-826-3061

COVID-19 Screening Questionnaire

Please complete this questionnaire prior to this and all subsequent visits to determine your eligibility to be seen. This form will be kept in your file.

1. Do you have any of the following symptoms:

- Fever
- new or worsening cough
- shortness of breath
- sore throat not related to a known or per-existing condition
- Rummy nose that is not related to a known of per-existing condition
- Nasal congestion that is not related to a known of per-existing condition
- difficulty swallowing
- nausea/vomiting/diarrhea/abdominal pain/ headache
- **Only over 70:** delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions

☐ YES
☐ NO

2. Have you travelled outside of Ontario or internationally within the last 14 days?

☐ YES
☐ NO

3. Have you had any unprotected close contract with individuals who have a confirmed of presumptive diagnosis of COVID-19?

☐ YES
☐ NO

Please note that answering YES to any of the above questions indicated that an individual is symptomatic of COVID-19 or may have been exposed to COVID-19 and are not eligible for care at this time and they are asked to take the Self-Assessment tool provided by the Ontario Ministry of Health – https://covid-19.ontario/self-assessment/

By signing this form and initialling at subsequent visits, I hereby confirm that the above information is true and correct to the best of my knowledge.

Name: _____ Signature: _____

Date: _____ Chiropractor Signature: _____

DATE	INITIAL	DATE	INITIAL

PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C = Constant F = Frequent O = Occasional

C F O

NEUROLOGICAL

☐ ☐ ☐ allergy
☐ ☐ ☐ chills
☐ ☐ ☐ convulsions
☐ ☐ ☐ dizziness
☐ ☐ ☐ fainting
☐ ☐ ☐ headaches
☐ ☐ ☐ loss of sleep
☐ ☐ ☐ nervousness
☐ ☐ ☐ depression
☐ ☐ ☐ neuralgia
☐ ☐ ☐ sweats
☐ ☐ ☐ loss of weight
☐ ☐ ☐ tremors

MUSCLE & JOINT

☐ ☐ ☐ arthritis
☐ ☐ ☐ bursitis
☐ ☐ ☐ foot trouble
☐ ☐ ☐ hernia
☐ ☐ ☐ low back pain
☐ ☐ ☐ neck pain
☐ ☐ ☐ neck stiffness
☐ ☐ ☐ pain between shoulders

RESPIRATORY

☐ ☐ ☐ chest pain
☐ ☐ ☐ chronic pain
☐ ☐ ☐ difficulty breathing
☐ ☐ ☐ spitting blood
☐ ☐ ☐ throat phlegm
☐ ☐ ☐ wheezing

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ colds
☐ ☐ ☐ crossed eyes
☐ ☐ ☐ deafness
☐ ☐ ☐ dental decay
☐ ☐ ☐ asthma
☐ ☐ ☐ ear aches
☐ ☐ ☐ ear discharge
☐ ☐ ☐ ear noises
☐ ☐ ☐ sinus infections

C F O

☐ ☐ ☐ enlarged glands
☐ ☐ ☐ enlarged thyroid
☐ ☐ ☐ sore throat
☐ ☐ ☐ tonsillitis
☐ ☐ ☐ eye pain
☐ ☐ ☐ failing vision
☐ ☐ ☐ far sighted
☐ ☐ ☐ gum trouble
☐ ☐ ☐ hay fever
☐ ☐ ☐ hoarseness
☐ ☐ ☐ near sighted
☐ ☐ ☐ nosebleeds

CARDIOVASCULAR

☐ ☐ ☐ rapid heart beat
☐ ☐ ☐ show heart beat
☐ ☐ ☐ swelling of ankles
☐ ☐ ☐ hardening of the arteries
☐ ☐ ☐ high blood pressure
☐ ☐ ☐ low blood pressure
☐ ☐ ☐ pain over heart
☐ ☐ ☐ poor circulation

GASTROINTESTINAL

☐ ☐ ☐ excessive hunger
☐ ☐ ☐ burping or gas
☐ ☐ ☐ liver troubles
☐ ☐ ☐ colitis
☐ ☐ ☐ colon trouble
☐ ☐ ☐ constipation
☐ ☐ ☐ diarrhea
☐ ☐ ☐ difficult digestion
☐ ☐ ☐ distension of abdomen
☐ ☐ ☐ stomach pain
☐ ☐ ☐ gall bladder trouble
☐ ☐ ☐ hemorrhoids
☐ ☐ ☐ intestinal worms
☐ ☐ ☐ jaundice
☐ ☐ ☐ poor appetite
☐ ☐ ☐ nausea
☐ ☐ ☐ vomiting
☐ ☐ ☐ vomit blood

C F O

SKIN

☐ ☐ ☐ boils
☐ ☐ ☐ bruise easily
☐ ☐ ☐ dryness
☐ ☐ ☐ hives or allergy
☐ ☐ ☐ itching
☐ ☐ ☐ skin rash
☐ ☐ ☐ varicose veins

GENITOURINARY

☐ ☐ ☐ bed wetting
☐ ☐ ☐ blood in urine
☐ ☐ ☐ loss of urine control
☐ ☐ ☐ kidney infection
☐ ☐ ☐ painful urination
☐ ☐ ☐ prostate trouble
☐ ☐ ☐ pus in urine
☐ ☐ ☐ smell of urine

PAIN OR NUMBNESS

☐ ☐ ☐ shoulders
☐ ☐ ☐ arms
☐ ☐ ☐ hands
☐ ☐ ☐ hips
☐ ☐ ☐ legs
☐ ☐ ☐ knees
☐ ☐ ☐ ankles
☐ ☐ ☐ feet
☐ ☐ ☐ painful tail bone
☐ ☐ ☐ sciatica
☐ ☐ ☐ swollen joints

FOR WOMEN ONLY

☐ ☐ ☐ cramps
☐ ☐ ☐ heavy flow
☐ ☐ ☐ light flow
☐ ☐ ☐ irregular cycle
☐ ☐ ☐ painful cycle
☐ ☐ ☐ discharge
☐ ☐ ☐ sore breasts

Menopausal: ☐ Yes ☐ No

Last menstruation date: _____

Pregnant: ☐ Yes ☐ No

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No Indoor activities: _____

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 More than 4 meals

Date of last Dental Examination: _____

Falls and accidents (list): _____

Surgeries and Operations (list): _____

Surgery recommended but not performed (list): _____

Do you take vitamins and minerals? ☐ Yes ☐ No List: _____

Have you ever been knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

List any medications or drugs you are currently taking:

_____

Have you previously been hospitalized? ☐ Yes ☐ No

Please list: _____

Any family health conditions of problems: ☐ Yes ☐ No

Please list: _____

Signature: _____ Date: _____