



Dr. Joshua R. Stehmeier Chiropractor Inc. #201 1433 St. Paul St. Kelowna, BC V1Y 2E4 Phone: 250-448-9097

PATIENT ENTRANCE FORM

Name: _____ Date: _____

Address: _____

City, Province: _____ Postal Code: _____

Contact Number Home: _____ Business/Cell: _____

Email: _____ Date of Birth(M/D/Year): _____

Age: _____ Marital status: _____

Spouse Name: _____ Children: _____

Occupation: _____ Name of Company: _____

Emergency contact: _____ Phone: _____

How did you hear about our office?: _____

Reasons for consulting The Kelowna Wellness Clinic: _____

Goals of care: _____

Please explain what good health means to you: _____

PREVIOUS CHIROPRACTIC CARE

Name: _____ Phone: _____

Do you have previous x-rays: YES NO If yes, when: _____

What Areas: _____

How would you rate the results of your previous chiropractic care: Excellent Good Fair Poor

MEDICAL DOCTOR

Name: _____ Phone: _____

Date of Last Appointment: _____ Date of Last Physical: _____

MEDICAL SPECIALIST

Name: _____ Phone: _____

Specialty: _____ Date of Last Appointment: _____

DENTIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

DENTAL SPECIALIST

Name: _____ Phone: _____

Specialty: _____ Date of Last Appointment: _____

List Past Dental Procedures: _____

NATUROPATH

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

MASSAGE THERAPIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

PHYSICAL THERAPIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

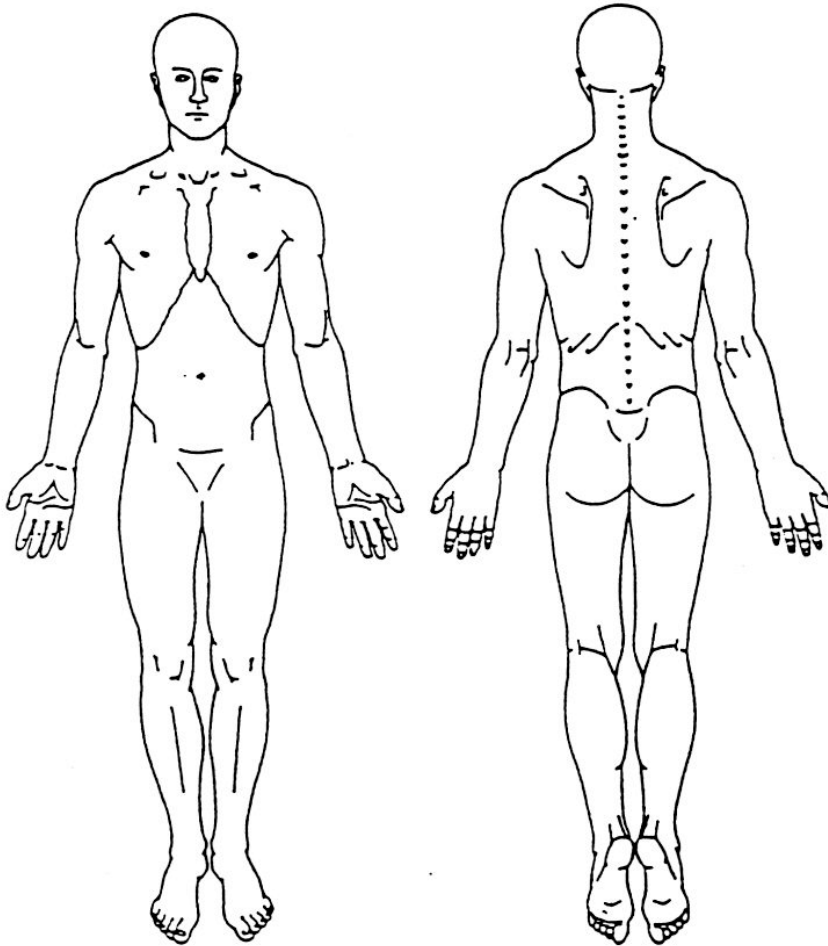
SURGERIES OR DIAGNOSTIC PROCEDURES

Please list any surgeries or medical procedures that you have had in the past 3 years:

Date:	Procedure:	Results:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please draw the location of the pain or discomfort you are experiencing in the images below. Use the symbols to represent the type(s) of pain:

D= Dull **B= Burning** **N= Numb** **S=Stabbing/Sharp** **T=Tingling(Pins and Needles)**



Please indicate on the wellness scale where you think you are in terms of your health at this point in time. We want you to take into account your physical, emotional, and spiritual health. Use an (X) on the line that will summarize your overall health.



PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms that you have had in the past year.

C = Constant

F = Frequent (weekly)

O = Occasional (monthly/yearly)

NEUROLOGICAL

- C** **F** **O**
 Allergy () () ()
 Chills () () ()
 Convulsions () () ()
 Dizziness () () ()
 Fainting () () ()
 Fevers () () ()
 Headache () () ()
 Loss of sleep () () ()
 Nervousness () () ()
 Depression () () ()
 Neuralgia () () ()
 Numbness () () ()
 Sweats () () ()
 Loss of weight () () ()
 Tremors () () ()

MUSCLES AND JOINTS

- C** **F** **O**
 Arthritis () () ()
 Bursitis () () ()
 Foot Trouble () () ()
 Hernia () () ()
 Low back pain () () ()
 Neck pain () () ()
 Neck stiffness () () ()
 Pain between shoulders () () ()
EYES, EARS, NOSE, THROAT
 Crossed eyes () () ()
 Eye pain () () ()
 Failing vision () () ()
 Far sighted () () ()
 Near sighted () () ()
 Deafness () () ()

GASTROINTESTINAL

- C** **F** **O**
 Excessive hunger () () ()
 Burping or gas () () ()
 Liver trouble () () ()
 Colitis () () ()
 Colon trouble () () ()
 Constipation () () ()
 Diarrhea () () ()
 Stomach pain () () ()
 Gall bladder trouble () () ()
C F O
 Hemorrhoids () () ()
 Intestinal Worms () () ()
 Jaundice () () ()
 Nausea () () ()
 Vomiting () () ()
 Blood in vomit () () ()

RESPIRATORY

- C** **F** **O**
 Chest pain () () ()
 Chronic cough () () ()
 Difficulty breathing () () ()
 Spitting blood () () ()
 Excess phlegm () () ()
 Wheezing () () ()
 Fever () () ()

Ear aches

- C** **F** **O**
 Ear aches () () ()
 Ear noises () () ()
 Colds () () ()
 Asthma () () ()
 Sinus infections () () ()
 Nasal obstruction () () ()
 Nose bleeds () () ()
 Enlarged glands () () ()
 Enlarged thyroid () () ()

GENITO- URINARY

- C** **F** **O**
 Bed wetting () () ()
 Blood in urine () () ()
 Frequent urination () () ()
 Uncontrolled Urine () () ()
 Kidney infection () () ()
 Painful urination () () ()
 Prostate trouble () () ()
 Pus in urine () () ()

CARDIOVASCULAR

- C** **F** **O**
 Rapid heart rate () () ()
 Slow heart rate () () ()
 Swelling of ankle () () ()
 Hardening of arteries () () ()
 High blood pressure () () ()
 Low blood pressure () () ()
 Pain over heart () () ()
 Poor circulation () () ()

PAIN OR NUMBNESS

- C** **F** **O**
 Shoulders () () ()
 Arms () () ()
 Hands () () ()
 Hips () () ()
 Legs () () ()
 Knees () () ()
 Ankles () () ()
 Feet () () ()
 Sciatica () () ()
 Swollen Joints () () ()

FOR WOMEN ONLY

- C** **F** **O**
 Cramps () () ()
 Heavy flow () () ()
 Light flow () () ()
 Irregular cycle () () ()
 Painful cycle () () ()
 Discharge () () ()
 Sore breasts () () ()
 Menopausal: **Y** **N**
 Pregnant **Y** **N**
 If pregnant, Due Date

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE

Do you smoke: Y N

Do you consume Alcohol: Y N

Do you exercise: Y N If yes, what type of exercise and how much: _____

Do you drink: Soda Pop Coffee any other caffeinated beverage: _____

Rate your sleep, hours per night: 4-6 6-8 8-10 12+

Do you wake rested: Yes No

Do you often feel fatigued during the day: Yes No

How often do you eat meals: 1-2 meals 2-3 meals 5+meals

Describe the type of food that you eat regularly: _____

Please list any Vitamins or Supplements that you are currently using: _____

List any current medications and the reason for taking them: _____

Have you previously been hospitalized: Yes No

If yes, please explain the reason: _____

REVIEW OF CONDITIONS (check all that apply)

Jaw:

When did you first start having problems in the jaw: _____

Please describe as: Ache _____ Stiff _____ Tight _____ Spasm _____ Sharp _____ Numb _____ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant _____ Daily _____ Weekly _____ Monthly _____ Irregular _____

What do you think caused the jaw problem to begin: _____

What area is involved: Left Side _____ Right side _____ Both _____

Do these pains: Stay Local ()

Originate from another Location () Where: _____

Travel to another Location () Where: _____

What makes the jaw problem better or worse: _____

On the scales below please indicate with a vertical line the pain that you feel from your jaw:

At the current time:

No Pain _____ Excruciating Pain

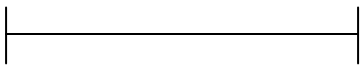


When it is at its least during the week:

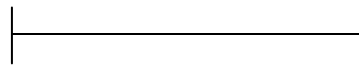
No Pain _____ Excruciating Pain



Average Pain during the week:



When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____

REVIEW OF CONDITIONS _____ (check all that apply)

Shoulders:

When did you first start having problems in the Shoulders: _____

Please describe as: Ache _____ Stiff _____ Tight _____ Spasm _____ Sharp _____ Numb _____ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant Daily Weekly Monthly Irregular

What do you think caused the shoulder problem to begin: _____

What area is involved: Left Side _____ Right side _____ Both _____

Does the shoulder problem: Stay Local ()

Originate from another Location () Where: _____

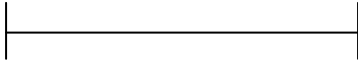
Travel to another Location () Where: _____

What makes the shoulder problem better or worse: _____

On the scales below please indicate with a vertical line the pain that you feel from your shoulder(s):

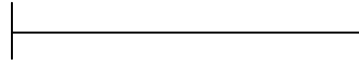
At the current time:

No Pain Excruciating Pain

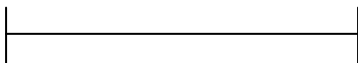


When it is at its least during the week:

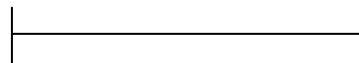
No Pain Excruciating Pain



Average Pain during the week:



When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____

REVIEW OF CONDITIONS (check all that apply)

Upper Extremities:

Do you experience any: Upper Arm _____ Lower Arm _____ Wrist _____ or Hand _____ discomfort?

When did the problem begin: _____

Please describe as: Ache _____ Stiff _____ Tight _____ Spasm _____ Sharp _____ Numb _____ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant _____ Daily _____ Weekly _____ Monthly _____ Irregular _____

What do you think caused the problem to begin: _____

What area is involved: Left Side _____ Right side _____ Both _____

Does the upper extremity pain: Stay Local ()

Originate from another Location () Where: _____

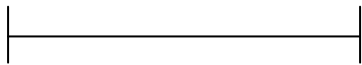
Travel to another Location () Where: _____

What makes the problem better or worse: _____

On the scales below please indicate with a vertical line the pain that you feel from your Upper extremity:

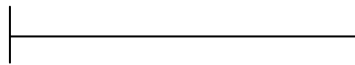
At the current time:

No Pain _____ Excruciating Pain

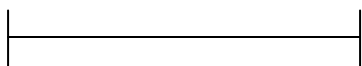


When it is at its least during the week:

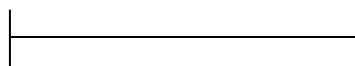
No Pain _____ Excruciating Pain



Average Pain during the week:



When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____

REVIEW OF CONDITIONS (check all that apply)

Low Back:

When did the problem begin: _____

Please describe as: Ache ___ Stiff ___ Tight ___ Spasm ___ Sharp ___ Numb ___ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant Daily Weekly Monthly Irregular

What do you think caused the problem to begin: _____

What area is involved: Left Side _____ Right side _____ Both _____

Does the low back pain: Stay Local ()

Originate from another Location () Where: _____

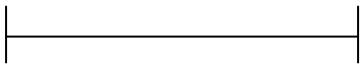
Travel to another Location () Where: _____

What makes the problem better or worse: _____

On the scales below please indicate with a vertical line the pain that you feel from your Lower back:

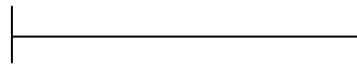
At the current time:

No Pain Excruciating Pain

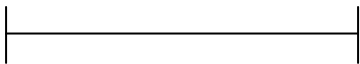


When it is at its least during the week:

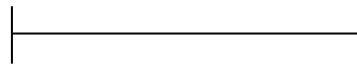
No Pain Excruciating Pain



Average Pain during the week:



When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____

REVIEW OF CONDITIONS _____ (check all that apply)

Hips:

When did the problem begin: _____

Please describe as: Ache _____ Stiff _____ Tight _____ Spasm _____ Sharp _____ Numb _____ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant Daily Weekly Monthly Irregular

What do you think caused the problem to begin: _____

What area is involved: Left Side _____ Right side _____ Both _____

Does the Hip pain: Stay Local ()

 Originate from another Location () Where: _____

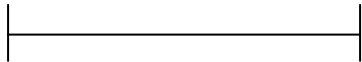
 Travel to another Location () Where: _____

What makes the problem better or worse: _____

On the scales below please indicate with a vertical line the pain that you feel from your Hip:

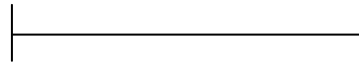
At the current time:

No Pain Excruciating Pain

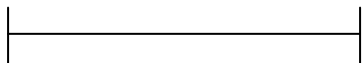


When it is at its least during the week:

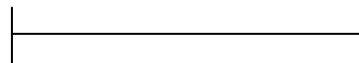
No Pain Excruciating Pain



Average Pain during the week:



When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____

REVIEW OF CONDITIONS (check all that apply)

Lower Extremities:

Do you experience any: Thigh ___ Knee ___ Lower leg ___ Ankle ___ or Foot ___ discomfort?

When did the problem begin: _____

Please describe as: Ache ___ Stiff ___ Tight ___ Spasm ___ Sharp ___ Numb ___ Other _____

How long does the problem last (please give a number or range): _____

Is the problem: Constant Daily Weekly Monthly Irregular

What do you think caused the problem to begin: _____

What area is involved: Left Side ___ Right side ___ Both _____

Does the Lower extremity pain: Stay Local ()

Originate from another Location () Where: _____

Travel to another Location () Where: _____

What makes the problem better or worse: _____

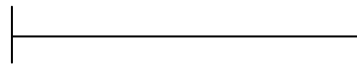
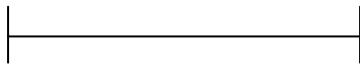
On the scales below please indicate with a vertical line the pain that you feel from your Lower extremity:

At the current time:

When it is at its least during the week:

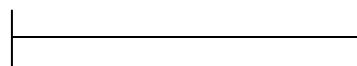
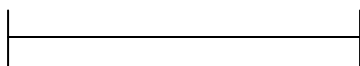
No Pain Excruciating Pain

No Pain Excruciating Pain



Average Pain during the week:

When it is at its worst during the week:



Patient Comments: _____

Doctor's Comments: _____