CHIROPRACTIC NEW PATIENT FORM

IT IS VERY IMPORTANT THAT WE COMPLETELY UNDERSTAND YOUR ISSUES. PLEASE TAKE THE TIME TO FILL THESE HEALTH HISTORY FORMS OUT THROUGHLY. This information will be kept confidential and will be used for no other purpose than for your chiropractor's clinical records. Please notify us if any of this information changes. If you have previously supplied us with contact information (address, phone numbers, emails) you may leave these areas blank.

Name: Date:

Address:

City, Province: Postal Code:

Cell Phone: Home Phone: Bus. Phone:

Email Address: Sex at Birth Preferred Pronoun:

Date of Birth ymd: Age:

Occupation:

Closest Relative: Phone :

How did you hear about our office: If referred, by whom?: May we contact them? Yes No

CLAIM WILL BE MADE AGAINST

1. Recent motor vehicle accident Yes No If YES, request additional forms

2. Work related injury or accident Yes No If YES, request additional forms

PRIOR CHIROPRACTIC CARE

Name: Phone :

Date of last visit: Fax :

MEDICAL DOCTOR

Name: Phone :

Address: Fax :

Date of Last Appointment : Date of Last Physical :

LIFESTYLE

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

Do you exercise? Yes No Do you use birth control pills? Yes No

Exercise Activities and their Frequency:

How would you rate your general health? Excellent Good Fair Poor Terrible

HEALTH HISTORY

What is the REASON for your visit today? HOW and WHEN did it start?:

Do you have a PREVIOUS HISTORY of this problems? Please explain.:

Is it getting... Better Worse No change Explain:

How would you DESCRIBE YOUR PAIN? Dull Stiff Sharp Shooting Numb Tingle Ache

Other:

Is the pain LOCAL or does it TRAVEL or RADIATE If so, where?:

What makes it WORSE?:

What makes it BETTER?:

Are there any OTHER SYMPTOMS you associated with it?:

Please check if any of the following apply to you? History of cancer Unexplained weight loss Unexplained fever or night sweats

Prolonged corticosteriod use Pain that wakes you up at night without moving Drug abuse, immunosuppressed or HIV

Please explain:

Have you seen OTHER PRACTITIONERS for this condition? MD Chiro Physio RMT Other:

Have you been provided with a DIAGNOSIS previously? If so, WHAT is it? Describe PREVIOUS TREATMENTS for your condition and their success.:

What MEDICAL TESTS have you been prescribed? X-rays CT Scan Ultrasound MRI Bloodwork Other

DATE of Test and RESULTS:

Previous FALLS and ACCIDENTS - brief description and dates:

Previous SURGERIES and HOSPITALIZATIONS - brief description and dates :

What is your FAMILY HEALTH HISTORY of medical conditions? ie. stroke, cancer, diabetes, etc.:

Describe any OTHER PERSONAL HEALTH CONCERNS.:

SYSTEMS REVIEW

PLEASE CHECK A BOX IN THE APPROPRIATE COLUMN FOR ANY OF THE SYMPTOMS OR CONDITIONS YOU HAVE EXPERIENCED. LEAVE BLANK IF YOU HAVE NOT EXPERIENCED THEM.

C = CONSTANT F = FREQUENT O = OCCASIONAL

C	F	O		C	F	O		C	F	O	
NEUROLOGICAL				EYES, EARS, NOSE and THROAT				CARDIOVASCULAR			
☐	☐	☐	allergy	☐	☐	☐	crossed eyes	☐	☐	☐	rapid heart beats
☐	☐	☐	chills	☐	☐	☐	eye pain	☐	☐	☐	slow heart beats
☐	☐	☐	convulsions	☐	☐	☐	failing vision	☐	☐	☐	hardening of arteries
☐	☐	☐	dizziness	☐	☐	☐	far sighted	☐	☐	☐	high blood pressure
☐	☐	☐	fainting	☐	☐	☐	near sighted	☐	☐	☐	low blood pressure
☐	☐	☐	fevers	☐	☐	☐	deafness	☐	☐	☐	pain over heart
☐	☐	☐	headaches	☐	☐	☐	ear aches	☐	☐	☐	poor circulation
☐	☐	☐	loss of sleep	☐	☐	☐	ear discharges	☐	☐	☐	swelling of ankles
☐	☐	☐	nervousness	☐	☐	☐	ear noises	☐	☐	☐	blood clots
☐	☐	☐	depression	☐	☐	☐	nasal obstruction				GENITO-URINARY
☐	☐	☐	neuralgia	☐	☐	☐	nosebleeds	☐	☐	☐	prostate trouble
☐	☐	☐	numbness	☐	☐	☐	sinus infections	☐	☐	☐	bed wetting
☐	☐	☐	sweats	☐	☐	☐	colds	☐	☐	☐	frequent urination
☐	☐	☐	loss of weight	☐	☐	☐	hay fever	☐	☐	☐	loss control urine
☐	☐	☐	tremors	☐	☐	☐	dental decay	☐	☐	☐	blood in urine
MUSCLE AND JOINT				☐	☐	☐	gum trouble	☐	☐	☐	painful urination
☐	☐	☐	arthritis	☐	☐	☐	enlarged glands	☐	☐	☐	pus in urine
☐	☐	☐	bursitis	☐	☐	☐	enlarged thyroid	☐	☐	☐	smell of urine
☐	☐	☐	swollen joints	☐	☐	☐	sore throat	☐	☐	☐	kidney infection
☐	☐	☐	neck	☐	☐	☐	tonsillitis	☐	☐	☐	kidney stones
☐	☐	☐	shoulders	☐	☐	☐	hoarseness	SKIN			
☐	☐	☐	blades	GASTRO			INTESTINAL	☐	☐	☐	boils
☐	☐	☐	upper back	☐	☐	☐	excessive hunger	☐	☐	☐	bruise easily
☐	☐	☐	arms	☐	☐	☐	burping or gas	☐	☐	☐	dryness

☐	hands	☐	poor appetite	☐	hives or allergy
☐	lower back	☐	nausea	☐	itching
☐	hips	☐	vomiting	☐	skin rash
☐	sciatica	☐	vomit blood	☐	varicose veins
☐	painful tailbone	☐	difficult digestion	FOR WOMEN	ONLY
☐	legs	☐	distension of abdomen	☐	cramps
☐	knees	☐	stomach pain	☐	heavy flow
☐	ankles	☐	hernia	☐	light flow
☐	feet	☐	liver trouble	☐	irregular cycle
RESPIRATORY		☐	jaundice	☐	painful cycle
☐	asthma	☐	gall bladder trouble	☐	discharge
☐	chronic cough	☐	colitis		
☐	spitting blood	☐	colon trouble		
☐	throat phlegm	☐	constipation		
☐	difficulty breathing	☐	diarrhea		
☐	wheezing	☐	hemorrhoids		
☐	chest pain	☐	intestinal worms		
		☐	diabetes		
		☐	low blood sugar		
		☐	high blood sugar		

Osteoporosis or Osteopenia? ☐ Yes ☐ No Date of bone scan: Medication details:

INFECTIOUS CONDITIONS

☐ Tuberculosis ☐ AIDS, HIV ☐ Hepatitis Type: ☐ Skin Type: Other:

FOR WOMEN ONLY

Menopausal? ☐ Yes ☐ No Last menstruation date:

Pregnant? ☐ Yes ☐ No Due date:

Do you have any OTHER MEDICAL CONDITIONS? List any MEDICATIONS or VITAMINS you are currently taking and what conditions they are for.:

Notes:

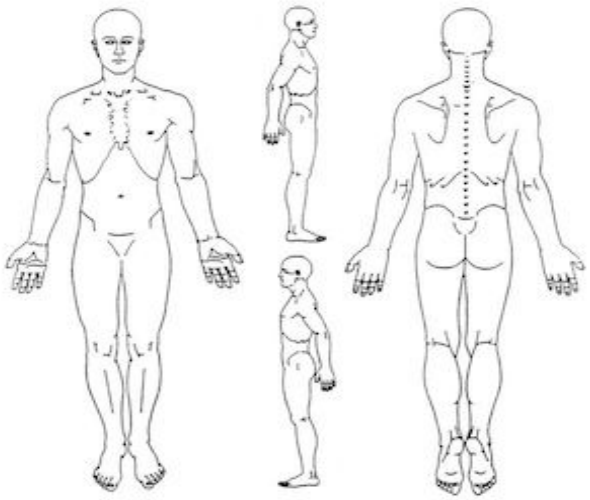
Notes:

PAIN SCALE AND PAIN DIAGRAM

On a scale of 0-10 rate the level of pain you are experiencing at this time. 0 is no pain and 10 is the worst pain you can imagine.

0-1 2 3 4 5 6 7 8 9 10

On the following diagram use the drawing tools to mark XXX for pain, /// for stiffness, and ... for numbness.



FEE SCHEDULE

Fees vary depending on the treatment rendered. Patients will be charged the regular fee on the subsequent visit unless a discussion with your chiropractor has determined that a more involved combination of treatments will be beneficial for you and your health care goals.

CHIROPRACTIC, ACUPUNCTURE, LASER AND/OR EXERCISE REHAB	PATIENT
INITIAL EXAMINATION (Approx. 45-60 mins.)	
Adult	$110.00
Student/Child	$90.00
SUBSEQUENT CHIROPRACTIC VISIT (Approx. 15 min.)	$55.00
EXTENDED CHIROPRACTIC VISIT (Approx. 15 mins.) Chiro with Acupuncture and or Laser	$65.00
CHIRO REHAB VISIT (Approx. 30 mins.) Chiro with Exercise Rehab	$80.00
INTENSIVE CHIROPRACTIC VISIT (Approx. 30 mins.) Complex Combination of Chiro, Rehab, Acup, and or Laser	$90.00

EXTENDED CHIROPRACTIC ASSESSMENT AND TREATMENT (Approx. 15-30 mins.) New Injury or Last Visit Greater Than 3 Mos.	$65-90.00
STUDENT Over 10 Years Old	Less $5.00
STUDENT Under 10 Years Old	Less $10.00
MISSED CHIROPRACTIC VISIT 24 Hours Notice Required	$35.00
ORTHOTICS	$500.00
X-RAY REQUISITION Per Series	$10.00

Payment is due at time service is rendered.

We accept cash, cheque, debit, MasterCard and Visa.

Chiropractic, Acupuncture and Laser are covered under Workplace Safety and Insurance Board, Motor Vehicle Accident Insurance and many Extended Health Care Plans. Any fees not accepted by the above are the patient's sole responsibility to pay.

SIGNATURE

This is to confirm and acknowledge that the above mentioned information is correct and accurate to my knowledge. I also acknowledge appointments cancelled less than 24 hours notice or any missed appointments will be subject to a missed appointment fee.

Patient Name: Date: Chiropractor's Name: Date Form Reviewed: