CONFIDENTIAL PATIENT INFORMATION

Name ....
(Last Name) (First Name)

Address ....
(Street #) (Street Name) (Apartment Number)

....
(City) (Postal Code)

Phone ....
(Home) (Business) (Extension)

Cell Phone .... E-mail Address ....

Age .... Birth Date ..../.........../........... Sex .... Marital .... No. of Children ....
month day year

Employer .... Occupation ....

How did you find out about our office? Web Page …... *yellowpages.ca* ….. Yellow Pages …...
Live in the area ...... Saw Sign ...... Friend or Relative …... My Doctor ..... My Employer …...

Please give us their name so we may thank them …………………………………………………………….

Who is your family doctor .... Address ....

May we contact your doctor regarding your chiropractic care? Yes .... No ....

Do you have insurance at work that covers chiropractic care? Yes ...... No ...... I don't know ……

If yes, what is your yearly limit? $……….. What percentage of each visit do they cover? ………..%

<u>MAJOR AREA OF COMPLAINT</u> (Please check all problem areas)

Neck	Shoulder	Arm	Mid back	Spinal check ....
Low Back	Hip	Leg	Headache	Migraine ....
Tension	Stress	Sinus	Allergies	Nervousness ....

Organic problems (asthma, indigestion, constipation, menstrual problems, etc) ....

Please list any other problems ....

Is this a Worker's Compensation Case? .... Claim Number .... Date ....

Is this an Automobile Case? .... Date of Accident …..

Have you been treated for any other health problems in the last 12 months? Yes .... No ....

If so, what was it for? ....

Have you ever had surgery? .... What kind(s)? ....

Have you ever been to a chiropractor before? .... Who? .... Last visit? ....

Date of last menstrual period? (female only) ....

Please ask about a chiropractic examination for your children and grand children.

I AM AWARE THAT OHIP DOES NOT COVER CHIROPRACTIC CARE AND
I ACCEPT FULL RESPONSIBILITY FOR MY ACCOUNT.

....
Signature of patient (or parent/guardian)

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