

## NEW PATIENT INFORMATION

### PERSONAL INFORMATION:

Mr.  Mrs.  Miss  Ms.  Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: Home ( \_\_\_ ) \_\_\_\_\_ Work( \_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_ Do not send me newsletter:

\*\*\*I prefer to be contacted by my home / work telephone number. (please circle)

Age: \_\_\_\_\_ Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Gender: M  / F

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_\_\_

Past chiropractic care: Yes  No  Chiropractor's Name: \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_

How did you hear about this office? Referral  Internet  Advertisement  Other  \_\_\_\_\_

What are your goals?:

- I am interested in receiving relief from my current symptom(s)
- I am interested in receiving relief from my current symptom(s) and preventing reoccurrence
- I am interested in the role of chiropractic in improving my general health

### BILLING INFORMATION:

General:

Extended Health Coverage: Yes  No  Provider's Name: \_\_\_\_\_

Type of Injury:

Is this a Workplace Safety and Insurance Board Injury? Yes  No

Date of Accident: \_\_\_\_\_ WSIB Claim Number: \_\_\_\_\_

Is this injury due to a motor vehicle accident? Yes  No

Date of Accident: \_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_

### **FEE SCHEDULE:**

<b>Initial visit (without treatment)</b>	<b>\$75</b>
<b>Subsequent visit -Adjustment</b>	<b>\$38</b>
<b>-Laser</b>	<b>\$38</b>

*Payment is expected, in the full amount, on the date that services are rendered.  
Patients will be charged for missed appointments.  
Please give 24 hours notification when unable to keep an appointment*

I have read the above information and understand that I am responsible for all charges relating to my visit

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HEALTH STATUS SURVEY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please check any conditions or symptoms below presently causing you problems, as well as those that have been a problem in the past.**

		present	past			present	Past			present	past
<b><u>GENERAL SYMPTOMS</u></b>				<b><u>E.E.N.T.</u></b>				<b><u>SKIN</u></b>			
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes, itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision (one/both eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives (allergy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>GASTROINTESTINAL</u></b>			
Clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringling, buzzing, any ear noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, pain or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting (blood?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Slurred or other speech problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>MUSCLES &amp; JOINTS</u></b>				Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>CARDIOVASCULAR</u></b>				Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood-pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Forearm pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>G.U. FOR WOMEN</u></b>			
Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart of blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or loss of strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b><u>GENTOURINARY</u></b>				Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>RESPIRATORY</u></b>				Trouble urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

Have you ever had any fractures? Yes  No

Have you ever been in a car accident? Yes  No

Have you ever been hospitalized? Yes  No  If yes, why? \_\_\_\_\_

Are you currently a smoker? Yes  No

Have you ever smoked in the past? Yes  No

Have you ever been diagnosed with cancer? Yes  No

Do you take medication on a regular basis? Yes  No  If yes, what? (blood thinner, blood pressure, etc.): \_\_\_\_\_