

REGISTRATION & HISTORY

Date _____

PATIENT INFORMATION	
Name: _____	
Address: _____	
City _____	Postal Code _____
Prov. _____	
Phone: _____	
Work / Cell: _____	
Email: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age: _____ D.O.B. _____
<input type="checkbox"/> Sing <input type="checkbox"/> Mar <input type="checkbox"/> Wid <input type="checkbox"/> Sep <input type="checkbox"/> Div	
Occupation: _____	
Employer: _____	
Spouse's Name: _____	
Occupation: _____	
Whom may we thank for referring you? _____	
**For all Insurance/Accident cases, additional forms may be required. Please inform receptionist.	

HEALTH INSURANCE	
Extended Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Co. _____	
Policy #: _____	
Name on acct: _____	
ACCIDENT INFORMATION	
Is condition due to an accident? Y / N _____ Date: _____	
Type of Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	
To Whom have you made a report of your accident?	
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other	
Name of Auto Ins.: _____	
Address: _____	
Adjuster's Name: _____	
Phone/Fax: _____	
Policy No. _____	Date of Loss: _____
Adjudicator Name _____	
Claim #: _____	
SIN #: _____	

Auto Accident
WSIB

PURPOSE OF CONSULTING WITH OFFICE (PLEASE CHECK ONE)

- I am interested only in help with my current condition(s), i.e. relief
- I am interested in help with my current condition(s) and learning how to correct and prevent it in the future, i.e. corrective care.
- I have no current problem, but I am interested in achieving the optimum level of function possible through preventive care. i.e. comprehensive care.

PATIENT CONDITION

Current symptom(s): _____	
When did your symptoms appear? _____	
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____	
Type of pain <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning	
<input type="checkbox"/> Tingling <input type="checkbox"/> Throbbing <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	
How often do you have this pain? _____	
Is it constant or does it come & go? _____	
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
Activities / Movements that are painful to perform <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	
What treatments have you already received for your condition? <input type="checkbox"/> Medical <input type="checkbox"/> Phys Thp <input type="checkbox"/> None <input type="checkbox"/> Other	
Name & address of other doctor(s) who have treated you for your condition _____	

SYMPTOMS PAST & PRESENT

Please **CIRCLE** any conditions/symptoms that are **PRESENT**
 Please **CHECK** those conditions/symptoms that were in the **PAST**

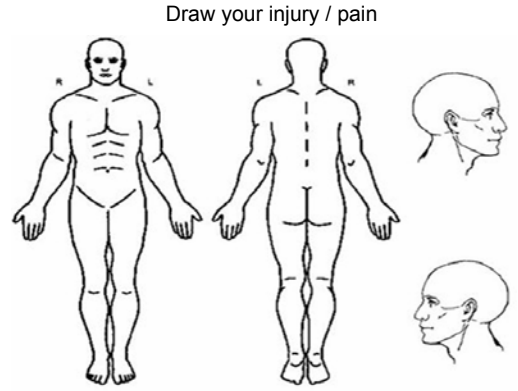
General Symptoms	Muscles & Joints	Eyes, Ear, Nose, Throat	Cardiovascular
Loss of consciousness	Stiff neck	Blurred vision	Heart/blood disease
Depression	Arthritis	Asthma	High blood pressure
Headache	Shoulder pain	Deafness	Bleeding disorder
Fevers	Wrist pain	Ear aches	Pain over the heart
Sweats	Hand pain	Ringing/Buzzing in ears	Stroke
Convulsions	Hip pain	Enlarged glands	Swelling of the ankles
Loss of Sleep	Knee pain	Enlarged thyroid	Poor circulation
Numbness, pain, tingling	Foot pain	Respiratory	Gastrointestinal
Loss of weight	Low back pain	Difficulty breathing	Poor appetite
Fainting	Back ache	Chronic cough	Nausea
Tremors	Bursitis	Spitting up phlegm	Constipation
Allergy	Swollen Joints	Spitting up blood	Diarrhea
Chills	Skin	Chest pain	Colitis
Convulsions	Rashes, itching	Genitourinary (women)	Irritable Bowel
Dizziness	Bruise easily	Excessive menstrual flow	Gallbladder trouble
Vomiting	Hives or allergy	Painful menstruation	
		Irregular menstrual cycle	
		Menstrual cramps	

HABITS	
<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> High Stress	Reason _____

EXERCISE	WORK ACTIVITY
<input type="checkbox"/> None	<input type="checkbox"/> Sitting
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing
<input type="checkbox"/> Heavy	<input type="checkbox"/> Light Labor
	<input type="checkbox"/> Heavy Labor

INJURIES & SURGERIES YOU HAVE HAD

Description	Date
Falls _____	
Head Injuries _____	
Fractures _____	
Dislocations _____	
Surgeries _____	



MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

IS THERE ANYTHING ELSE YOU WISH TO TELL US?

INFORMED CONSENT TO CHIROPRACTIC CARE AND SPINAL MANIPULATION

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the doctor of chiropractic named.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

 PRINT Patient's Name

 Signature of Patient

 Date Signed

 Witness to Patient's Signature