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Chiropractic Initial Consultation Form

Patient Number: _____

Date: _____ Referred by: _____

How did you hear about us? _____

Personal Information (Confidential)

Mr. Mrs. Miss Ms. Dr. Single Married Separated Divorced Widowed

First Name/Last Name: _____

If patient is a minor, name of parent/guardian: _____

Address: _____

City/Town: _____ Postal Code: _____

Home Telephone: (_____) _____ Email: _____

Birth Date (DD/MM/YY): ____/____/____ Children? Yes No Ages: _____

Occupation: _____ Work Telephone: (_____) _____ Ext _____

Employer: _____

Emergency Contact: _____ Phone: (_____) _____

Medical Doctor: _____ Phone: (_____) _____

Permission to contact and release personal information to Medical Doctor:

Authorizing Signature: _____ Date: _____

Insurance Company other than OHIP: _____

Previous Chiropractic Care: _____

Is this a work-related injury? Yes No If yes, Social Insurance Number _____

Is this an auto accident claim? Yes No

The clinic requires your permission to call you at home and/or your place of business, and to leave messages.

Please indicate your preference. Home Business Either

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that the cancellation policy dictates that missed appointments will be charged.

PAYMENT IS EXPECTED AT TIME OF VISIT.

Signature (Parent/Guardian if patient is a minor): X _____

Health Profile

Age: _____ _Male _Female

What is your major complaint? (Purpose of this appointment): _____

How long have you had this condition? _____

Have you had this condition before? _Yes _No When? _____ Was it treated? _Yes _No

If Yes, by: _Chiropractor _Family Doctor _Physical Therapist _Other: _____

What caused your complaint to begin? _____

Where do you feel it most? _Right Side _Left Side _Equal Both Sides

Describe your pain: _Sharp _Dull _Achy _Burning _Numb _Pins and Needles

What activities/positions make your condition worse? _____

What activities/positions make your condition better? _____

Does the pain awaken you at night? _Yes _No _Occasionally

Major Surgeries/Operations: _____

Major accidents or falls: _____

Hospitalizations (other than above): _____

Do you have any internal wires, pins, artificial joints or a pacemaker? _____

Have you been treated for any health conditions in the last year? _Yes _No

Please explain: _____

Current Medications: _____

Please list any vitamins/supplements: _____

Have you ever suffered from:

- | | | | | |
|------------------------------------|------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthriti | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Allergies | _____ | |

Are you currently pregnant? Yes / No

On the figures below, please mark your areas of pain.

Pain Scale (circle one)

with 0 being no pain and 10 being the worst pain imaginable

At its **Worst**:

Min 0 1 2 3 4 5 6 7 8 9 10 Max

At the **Present time**:

Min 0 1 2 3 4 5 6 7 8 9 10 Max

