PATIENT INFORMATION

FILE#_____
(for office use only)

Name:_____ M ☐ F ☐
(Surname) (First Name)

Address:_____Postal Code:_____
(Street) (Apt#) (City)

Home Phone#:_____Work Phone#:_____

Cell Phone#:_____Email address:_____

◇ *Consent to receive clinic news and updates via email?* *Yes* □ *No* □
◇ *Which phone number is your best contact number?* *Home*□ *Work*□ *Cell*□

Birth Date:_____Age:_____Occupation_____
(month/day/year)

Family Doctor's Name:_____Phone #:_____

◇ *How did you hear about us?* _____

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HEALTH INFORMATION & TREATMENT HISTORY

I AM HERE AS A RESULT OF A: a) car accident_____ b) work injury_____ c) other_____

Date of Accident/Injury:_____

Major / Secondary Complaint:_____

How long have you had this condition?_____

Secondary Complaint(s):_____

Have you seen your family doctor regarding this condition?_____

Date of visit:_____ Doctor's Name:_____

Have you had previous chiropractic care?_____

Date of visit:_____ Doctor's Name: _____

Have you had previous physiotherapy treatment? _____

Same condition? _____ Other: _____ Date of visit: _____

Have you had previous massage therapy treatment? _____

Same condition? _____ Other: _____ Date of visit: _____

Have you had X-rays taken? If so, when? _____