REGISTRATION & HISTORY

Date ______________________

PATIENT INFORMATION

Name: ______________________

Address: ______________________

City | Prov. | Postal Code

Phone: ______________________

Work / Cell: ______________________

Email: ______________________

Sex: □ M □ F Age: D.O.B. ____________

□ Sing □ Mar □ Wid □ Sep □ 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: □ Yes □ No

Insurance Co. ______________________

Policy #: ______________________

Name on acct:

ACCIDENT INFORMATION

Is condition due to an accident? Y / N Date: ____________

Type of Accident □ Auto □ Work □ Home □ Other

To Whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Worker Comp. □ Other

Auto Accident

Name of Auto Ins.: ______________________

Address: ______________________

Adjuster's Name: ______________________

Phone/Fax: ______________________

Policy No. Date of Loss:

WSIB

Adjudicator Name ______________________

Claim #: ______________________

SIN #:

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? □Yes □No □Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain □ Sharp □ Dull □ Numbness □ Aching □ Shooting □ Burning
□ Tingling □ Throbbing □ Stiffness □ Swelling □ Other ____________

How often do you have this pain? ______________________

Is it constant or does it come & go? ______________________

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities / Movements that are painful to perform □ Sitting □ Standing □ Walking □ Bending □ Lying Down

What treatments have you already received for your condition? □ Medical □ Phys Thp □ None □ 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/symtoms that were in the **PAST**

General Symptoms
- Loss of consciousness
- Depression
- Headache
- Fevers
- Sweats
- Convulsions
- Loss of Sleep
- Numbness, pain, tingling
- Loss of weight
- Fainting
- Tremors
- Allergy
- Chills
- Convulsions
- Dizziness
- Vomiting

Muscles & Joints
- Stiff neck
- Arthritis
- Shoulder pain
- Wrist pain
- Hand pain
- Hip pain
- Knee pain
- Foot pain
- Low back pain
- Back ache
- Bursitis
- Swollen Joints

Skin
- Rashes, itching
- Bruise easily
- Hives or allergy

Eyes, Ear, Nose, Throat
- Blurred vision
- Asthma
- Deafness
- Ear aches
- Ringing/Buzzing in ears
- Enlarged glands
- Enlarged thyroid

Respiratory
- Difficulty breathing
- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain

Genitourinary (women)
- Excessive menstrual flow
- Painful menstruation
- Irregular menstrual cycle
- Menstrual cramps

Cardiovascular
- Heart/blood disease
- High blood pressure
- Bleeding disorder
- Pain over the heart
- Stroke
- Swelling of the ankles
- Poor circulation

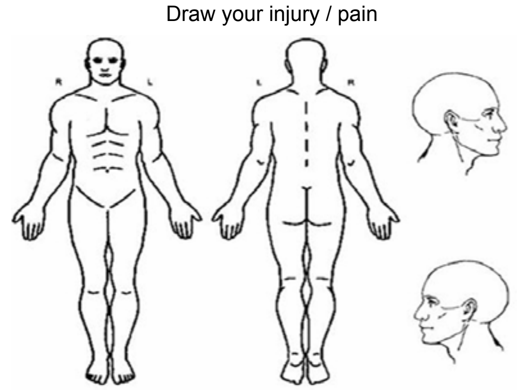
Gastrointestinal
- Poor appetite
- Nausea
- Constipation
- Diarrhea
- Colitis
- Irritable Bowel
- Gallbladder trouble

HABITS

□ Smoking	Packs/Day	______
□ Alcohol	Drinks/Week	______
□ Caffeine Drinks	Cups/Day	______
□ High Stress	Reason	______

EXERCISE	WORK ACTIVITY
□ None	□ Sitting
□ Moderate	□ Standing
□ Heavy	□ Light Labor
	□ Heavy Labor

Draw your injury / pain



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