



# New Patient Form

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

Mr.       Mrs.       Miss       Ms.       Dr.

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

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Gender: F       M

Street Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_

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

Email: \_\_\_\_\_

Phone: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Please check if we can leave a message at that number

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have extended health care insurance? Yes or No

If so, which insurance company? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

How long have you had the particular injury/condition that has brought you to our office?

What is this injury/condition preventing you from doing? \_\_\_\_\_

What have you tried in the past to treat this injury/condition? \_\_\_\_\_

Family Physician's name: \_\_\_\_\_

Family Physician's telephone: \_\_\_\_\_ MSI #: \_\_\_\_\_

## Previous Chiropractic Treatment N/A

Previous chiropractor's name: \_\_\_\_\_

Date of last chiropractic visit: \_\_\_\_\_

Previous Imaging? (X-Ray/CT Scan/MRI): \_\_\_\_\_

Body Region Imaged: \_\_\_\_\_

Date of Imaging: \_\_\_\_\_

Location Imaging Taken: \_\_\_\_\_

**Type of Injury**

Name: \_\_\_\_\_

Is this a Worker's Compensation Board Injury? Yes  No

*(If yes, please fill in the following information)*

Social insurance number \_\_\_\_\_

WCB claim number \_\_\_\_\_ Date of accident \_\_\_\_\_

Employer's name: \_\_\_\_\_

Employer's address and telephone: \_\_\_\_\_

Are your injuries related to a motor vehicle case? Yes  No

*(If yes, please fill in the following information)*

Date of accident: \_\_\_\_\_

Insurer's name: \_\_\_\_\_

Policy or claim number: \_\_\_\_\_

Insurer's address and telephone: \_\_\_\_\_

**SYMPTOM DIAGRAM**

Please indicate (using the symbols) the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing:

**Numbness:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

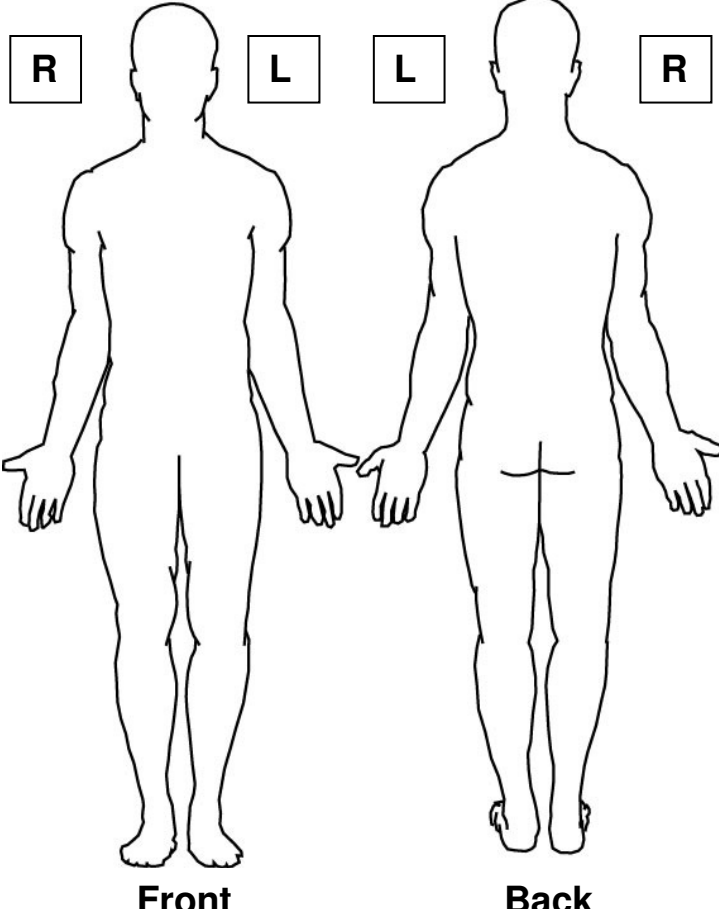
**Burning:** X X X X X X  
X X X X X X  
X X X X X X

**Pins & Needles:** . . . . .  
. . . . .  
. . . . .

**Stabbing / Sharp:** // // // // //  
// // // // //  
// // // // //

**Dull & Aching:** + + + + +  
+ + + + +  
+ + + + +

**Stiff & Tight:** T T T T T  
T T T T T  
T T T T T



**Front**

**Back**

**HEALTH STATUS SURVEY** Name: \_\_\_\_\_

Please circle any conditions or symptoms you are **presently** experiencing.

Please  $\checkmark$  any of the following that you have experienced **in the past**.

<p><b>General Symptoms</b></p> <p>Loss of Consciousness Headache Fever Sweats Fainting Dizziness Clumsiness Convulsions Loss of sleep Numbness or Tingling Nervousness Weight Loss</p> <p><b>Muscles &amp; Joints</b></p> <p>Persistent Stiffness Back Ache Swollen Joints Painful Tailbone Shoulder Pain Arm/Forearm Pain Elbow Pain Wrist/Hand Pain Arthritis Weakness</p>	<p><b>E.E.N.T</b></p> <p>Blurred Vision Failing Vision Crossed Eyes Double Vision Eye Pain Deafness Earache Ringing/Buzzing in Ear Asthma Frequent Colds Sinus Infection Enlarged Glands Enlarged Thyroid Slurred Speech Difficulty Swallowing</p> <p><b>Respiratory</b></p> <p>Chronic Cough Spitting up Phlegm Spitting up Blood Chest Pain Difficulty Breathing</p>	<p><b>Cardiovascular</b></p> <p>Bleeding Disorder High Blood Pressure Pain Over Heart Stroke Hardening of Arteries Varicose Veins Swelling of Ankles Poor Circulation Heart or Blood Disease Angina</p> <p><b>Genitourinary</b></p> <p>Trouble Urinating Blood in Urine Kidney Infection Bed Wetting Prostate Problems</p> <p><b>Skin</b></p> <p>Rashes, Itching Bruise Easily Dryness Boils Hives (Allergy)</p>	<p><b>Gastrointestinal</b></p> <p>Poor Appetite Indigestion Excessive Hunger Belching or Gas Nausea Vomiting (Blood?) Pain over Stomach Constipation Diarrhea Hemorrhoids (Piles) Jaundice Gall Bladder Trouble Intestinal Worms Ulcer Diabetes</p> <p><b>G.U. for Women</b></p> <p>Painful Menstruation Excessive Flow Hot Flashes Irregular Cycle Cramps Back/Headache Vaginal Discharge Swollen Breasts Lumps in Breasts</p>
--	--	--	---

**Women Only:**

Have you ever been on birth control pills?      Yes      No

Are you currently taking the birth control pill?      Yes      No

# of Pregnancies \_\_\_\_\_ # of Children \_\_\_\_\_

Have you ever had any fractures?      Yes      No      If so, what? \_\_\_\_\_

Have you ever sustained any injury from a car accident?      Yes      No

Do you currently smoke?      Yes      No      For how long? \_\_\_ months/years

~ If No, have you smoked in the past?      Yes      No      For how long? \_\_\_ months/years

Have you ever been diagnosed with cancer?      Yes      No

Please list any medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

Please list any supplements/vitamins you take: \_\_\_\_\_