New Patient Form (Chiropractic)

□ 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 or reminder call at that number

Reminders: □ Text □ Phone □ Email

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 #: __________________ Exp:_____

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

Body Region Imaged:____

Date of Imaging:____

Location Imaging Taken: ____

Previous Chiropractic Treatment N/A □

Previous chiropractor's name:____

Date of last chiropractic visit:____

Please be advised that your health information will be shared only with the authorized practitioners providing treatment to you.

Type of Injury

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: ____

PLEASE NOTE, WE DO NOT ACCEPT WORKER'S COMPENSATION BOARD CLAIMS.

Cancellation Policy

Twenty-four (24) hours notice, outside of illness, emergency, or severe weather conditions, is required for cancelling or rescheduling appointments. A fee of 100% of the treatment may be payable on the cancellations without adequate notice and "no-shows".

Consent

I have read the above, and agree and understand that I am responsible for all charges relating to my visit.

Date: ______________________ Signature: __________________________________

Patient/Guardian if patient is under 18 years of age

ACTIVE APPROACH Health & Wellness Centre

HEALTH STATUS SURVEY **Name:** ____________________

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

Please √ any of the following that you have experienced **in the past**.

General Symptoms
Loss of Consciousness
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness or Tingling
Nervousness
Weight Loss
Weakness

Muscles & Joints
Persistent Stiffness
Back Ache
Swollen Joints
Painful Tailbone
Shoulder Pain
Arm/Forearm Pain
Elbow Pain
Wrist/Hand Pain
Arthritis
Knee Pain
Neck Pain

E.E.N.T
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

Respiratory
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficulty Breathing

Cardiovascular
Bleeding Disorder
High Blood Pressure
Pain Over Heart
Stroke
Hardening of Arteries
Varicose Veins
Swelling of Ankles
Poor Circulation
Heart or Blood Disease
Angina

Genitourinary
Trouble Urinating
Blood in Urine
Kidney Infection
Bed Wetting
Prostate Problems

Skin
Rashes, Itching
Bruise Easily
Dryness
Boils
Hives (Allergy)

Gastrointestinal
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

G.U. for Women
Painful Menstruation
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps
Back/Headache
Vaginal Discharge
Swollen Breasts
Lumps in Breasts

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: ________________________________

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 _____________.

Please Turn Over

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