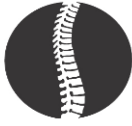

CREDIT VILLAGE FAMILY CHIROPRACTIC CENTRE

File Number:__________________

All of the information you provide will remain strictly confidential.

Name:_____________________________________ Sex: M F D.O.B. (D/M/Y):______________________

Address:______________________________________ City:__________________ Postal Code:_________________

Home Phone: ___________________ Work Phone:____________________ Cell Phone:______________________

E-mail Address:____ Occupation:_______________________

Family Physician:____ Date of Last Visit:______________________

M.D. Address:____ Phone:______________________

To promote co-operation between your health care providers, we will send a consultation or progress letter to your family physician. *If we have your consent to do so, please sign your name here:* ____________________________________

What is the reason for your visit today?____

____

Is your visit due to a car accident? Y N If yes, date of accident:____________________________

Is your visit due to a work injury? Y N If so, date of accident:____________________ Claim #:___________________

How did you hear about this clinic? (*please circle*) Yellow pages Internet/Website Friend/Relative

Health Professional Other:__________________________

Do any of the following apply to you? (*please circle and provide details*)

Severe accidents/falls Hospitalization/Surgery Serious Illness Fractures Allergies X-rays/MRI

____

____

Do you currently experience…(please circle all that apply)?

Headache	Chest Pain	Heartburn/Gas	Painful Urination
Fainting/Blackouts	High Blood Pressure	Abdominal Pain	Numbness/Tingling
Dizziness	Breathing Troubles	Diarrhea	Swelling
Seizures	Premenstrual Syndrome	Constipation	Weakness
Anxiety/Depression	Unusual Bleeding	Frequent Urination	Fatigue

List any medications/supplements you are currently taking: ____

____

Sleep Quality: low 1 2 3 4 5 high Stress Levels: low 1 2 3 4 5 high

Diet Quality: low 1 2 3 4 5 high Activity Level: low 1 2 3 4 5 high

Do you smoke? Y N Do you drink? Y N Are you Hepatitis or HIV positive? Y N Maybe

CREDIT VILLAGE FAMILY
CHIROPRACTIC CENTRE

File Number:__________________

Do you have a family history of....(please circle)?

Mother's Side	Cancer	Heart Disease	Stroke	Diabetes	Arthritis
Father's Side	Cancer	Heart Disease	Stroke	Diabetes	Arthritis

Where is your pain located? (*please draw on the diagram below*)

Right Left Right Left Left Right Right Left
R L L R
Left Right
Right Left
Left Right

When/how did it first begin?____

____

Is your pain ....(please circle)? Better Worse About the same Comes and goes

Do you feel it....(please circle)? Monthly Weekly Daily Constantly Other____________________

Does it feel....(please circle)? Sharp Dull Achy Numb Pins & Needles Burning Tight

Show us how intense your pain is ***(please mark)***: **NO PAIN** .... **WORST PAIN EVER FELT**

What makes your pain worse?____

What relieves your pain?____

Have you received any treatment for your condition? Y N Please describe:____________________

____

WSIB will be billed directly on my behalf for clinic services. Billing for Accident Benefits due to a motor vehicle accident will be discussed with me. Payment in full is expected when the service is rendered. There is no charge for missed appointments, although I am asked to call ahead to cancel and re-schedule your appointment. I understand that I am responsible for all charges relating to my visit. (Parent/Guardian must sign if the patient is under 18 years of age).

________________________________ ________________________________ 20_____/_____/_____

Print Patient Name Signature of Patient/Legal Parent or Guardian Year Month Day