CONFIDENTIAL PATIENT INFORMATION

NAME:____ DATE OF BIRTH: d_____ m_____ y_____

ADDRESS: ____ CITY: ______________________

POSTAL CODE: _________ HOME PHONE: _______________ BUS. PHONE: ________________

EMAIL ADDRESS:____

EMPLOYER NAME: ____

EXTENDED HEALTH COVERAGE? NO YES

Massage therapy $___________, Orthotics $___________, Naturopathic Doctor $___________

REFERRED BY: _______________________________RELATIONSHIP:______________________

SPOUSE NAME: _______________ NO. OF CHILDREN: _____ DOCTOR: ___________________

PURPOSE OF APPOINTMENT: ____

IS THIS CONDITION GETTING WORSE? NO YES → ______________________________

INTERFERES WITH → WORK? ________SLEEP? _________ DAILY ROUTINE? ____________

HAVE YOU BEEN PREVIOUSLY TREATED FOR THIS? NO YES →______________________

HOW HAS YOUR CONDITION AFFECTED YOUR LIFESTYLE?___________________________

____

OTHER CONCERNS: ____

PREVIOUS CHIROPRACTIC CARE? NO YES →WHOM? ______________ WHEN? __________

LIST ANY SURGICAL OPERATIONS: ____

LIST MEDICATIONS: ____

VITAMINS OR NATURAL REMEDIES: ____

HAVE YOU BEEN INVOLVED IN ANY ACCIDENTS? _____auto _____ home _______work ______sports

FAMILY MEMBERS WITH PAST OR PRESENT SPINAL PROBLEMS: _____________________

STUDENTS – PLEASE LIST PERMANENT ADDRESS: ___________________________________

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