Confidential Patient Information Form

CARE CARD NUMBER: _____ TODAYS DATE: _____

NAME: MR/MRS/MS _____ DATE OF BIRTH: _____

ADDRESS: _____ POSTAL CODE: _____

PHONE (H) _____ PHONE (W)_____

PHONE (Cell) _____ E-mail address: _____

OCCUPATION: _____ EMPLOYER: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE ☐ Phone Book ☐ Internet ☐

Who referred you?_____

Your last chiropractor: _____ Date of adjustment _____ Date of x-ray's_____

Your last physiotherapist_____ Your medical doctor: _____

May we forward a clinical progress note to your family doctor? ☐ Yes ☐ No

OFFICE USE ONLY

Complaints: ☐ Low back pain ☐ Upper back pain ☐ Headaches ☐ Hip
☐ Neck pain ☐ Shoulder pain ☐ Other _____

How long have you had this problem and what caused it?

_____

Have you had it before?: ☐ NO ☐ YES When? _____

Is the pain constant ☐ or does it come and go ☐?

Is your condition getting worse? ☐ NO ☐ YES

What makes your symptoms worse?

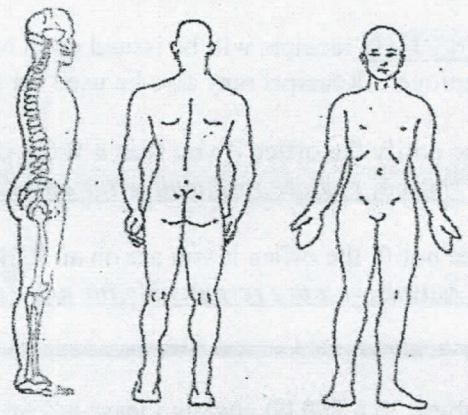
_____

What helps to lessen your symptoms?

_____

Please indicate location of symptoms:

pins and needles xxxxx
stabbing pain ≈≈≈≈
burning pain ///////
aching pain ooooo



Do you have a history of: ☐ High blood pressure ☐ Diabetes ☐ Cancer ☐ Asthma ☐ Rheumatic fever
☐ Arthritis
☐ Other current health problems

_____

Please Turn Over →

Current or recent medication/vitamins:

_____

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PAST INJURIES — **Please Specify**

Have you had any car accidents?	Yes☐ No☐	When? _____	_____
Have you had any other serious injuries?	Yes☐ No☐	When? _____	_____
Have you broken any bones?	Yes☐ No☐	When? _____	_____
Have you had any major surgery?	Yes☐ No☐	When? _____	_____
Have you had any unusual childhood diseases?	Yes☐ No☐	When? _____	_____

WOMEN ONLY

How many times have you been pregnant ? _____

How many children do you have ? _____ How old are they?_____

Were any of them a difficult birth? _____ Explain: _____

When was your most recent menstrual period? _____

Are your periods regular? ____YES ____NO If no, how often? _____

Do you have pre-menstrual discomfort? ☐ YES ☐ NO

OFFICE FEES & POLICIES

M.S.P provides partial coverage **only for persons on premium assistance**. Fees related to x-ray examinations, insurance reports and requested letters are the patient's responsibility. ***Fees are due on day of service.***

Initial consultation: $ _____ Subsequent visits: $ _____

EXTENDED HEALTH BENEFITS PLAN receipts will be issued upon request. If you are unsure of your EHB coverage, please check with your employer. Receipts may also be used for tax purposes.

WCB CLAIMS are accepted. Please notify the office if you start a WCB claim.
If your claim is not covered for any reason, you are responsible for any outstanding amounts.

ICBC CLAIMS are accepted. Please notify the office if you are on an ICBC claim.
If your claim is not covered for any reason, you are responsible for any outstanding amounts

MISSED APPOINTMENTS are subject to a **$50.00 charge.**Please advise us **24 hours** ahead or at your earliest opportunity if you are unable to keep a scheduled appointment and we will arrange another for you at the next available time.

I have read the above policies and understand and accept my responsibilities as a patient.

Signature _____ Date _____