



Initial _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____
Update 5 _____

CHIROPRACTIC HEALTH HISTORY

PERSONAL INFORMATION

Name:	Date:
Address:	
Home Phone:	Work Phone:
e-mail:	Gender: M / F
Date of Birth:	Occupation:
Emergency Contact (name):	Relation to you:
Emergency Contact (number):	
What is your primary reason for today's visit?	How did you hear about our clinic?

MEDICAL INFORMATION

OHIP number:	Version Code:
Family Physician:	
Address:	Phone:
May we contact if necessary? Y / N	
Current Medications?	For what?
Present involvement in other healthcare? Y / N	If yes, please explain:

INSURANCE INFORMATION

Are you making an insurance claim?	Claim number:
Recent Motor Vehicle Accident? Y / N	Work related injury/Accident (WSIB)?
If yes, please describe:	Date of accident/injury:
Present involvement in other healthcare? Y / N	If yes, please explain:
Prior to this claim, have you ever had any complaints in the involved area? Y / N	If yes, when?

PREVIOUS CHIROPRACTIC CARE

Have you ever received chiropractic care in the past? Y / N	
Name of chiropractor:	Phone:
Date last seen:	May we contact if necessary? Y / N
Reason for seeking care?	Results: excellent / good / fair / poor

FAMILY HISTORY

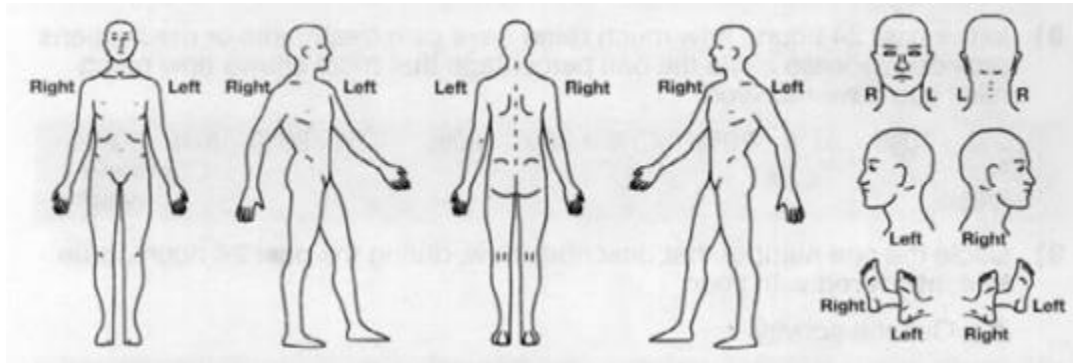
cancer stroke diabetes hypertension

LIFESTYLE

smoke Y / N alcohol: ___ glasses / week balanced diet regular exercise

YOUR MEDICAL HISTORY

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> fainting | <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of sleep | <input type="checkbox"/> fatigue | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> paralysis | <input type="checkbox"/> tingling | <input type="checkbox"/> palpitations | <input type="checkbox"/> arthritis | <input type="checkbox"/> headaches |
| <input type="checkbox"/> migraines | <input type="checkbox"/> epilepsy | <input type="checkbox"/> hepatitis | type: (OA/RA/Other) | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> heart disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> phlebitis | <input type="checkbox"/> stroke | <input type="checkbox"/> warts/athletes foot | <input type="checkbox"/> skin rashes/infections | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> cancer | <input type="checkbox"/> swelling | <input type="checkbox"/> poor circulation | explain: | <input type="checkbox"/> bone disease |
| <input type="checkbox"/> neurological disease | <input type="checkbox"/> injury/surgery nature: _____ date: _____ | <input type="checkbox"/> injury/surgery nature: _____ date: _____ | <input type="checkbox"/> pregnant due date: _____ | <input type="checkbox"/> allergies/sensitivities type: _____ |



If applicable, on the diagram to the left, please mark the location of your primary complaint, using the symbols below.

- A - ache
- S - sharp/stabbing
- N - numbness
- T - tingling
- /// - stiffness
- D - deep
- B - burning

How did your symptoms start? sudden gradual car accident work related injury
 When did your symptoms start? 0-3 months ago 3-6 months ago 6-9 months ago 1 year ago or more

Please mark the level of your discomfort on the line below:

0-----10

Office Policies:

Scheduling: To make appointments available to other patients, cancellation requires 24 hours notice. Missed appointments without notice will be charged a \$25 fee. Drop-ins are welcome, however scheduled appointments will be seen first. If you are late for your visit, the doctor will take the next scheduled patient, if there are no immediate openings, you will be required to wait for the next available opening, or reschedule for another time.

Payment: Payment is expected in full each visit, unless previous arrangements have been made. We accept cash, cheque, debit, visa and mastercard. NSF cheques will be charged a \$25 fee. Preauthorized credit card payments and prepaid plans are available to speed up visit time, please ask front desk for more information. Should you discontinue care for whatever reason, any outstanding balance will become due immediately.

Fees: In order to accommodate the varying needs and preferences of our patients, and the time involved in the different types of care provided, appointments will be charged by time. Appointment types include:

- Initial Consultation & Examination: \$100.00
- Regular subsequent Visit: \$40.00
- Extended Visit: \$60.00

I have read the above and agree and understand that I am responsible for all charges relating to my visit. (A parent/guardian must sign if the patient is under 18 years of age)

I acknowledge and understand for Dr. Baker to provide a reasonable assessment of my condition, a physical examination will be necessary. By signing below, I provide my consent to examination for the purpose of diagnostic.

SIGNATURE

DATE