**Patient Information** (All information provided is confidential)

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Mr. ○ Mrs. ○ Miss. ○ Ms. ○ Dr. ○

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_

Health Card: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_\_\_ Month: \_\_\_\_\_\_ Year: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it alright to leave a message? Yes \_\_\_\_ No \_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ○ Single ○ Married ○ Divorced

○ Cohabitating ○ Separated ○ Widowed

Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chiropractic Experience: Yes \_\_\_\_ No \_\_\_\_

Previous Chiropractors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chiropractors Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this clinic?

Word of Mouth ○ Facebook ○ Google ○ Signage ○

Personal Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Information**

Is this a Workers’ Compensation Board (**WCB**) Injury? Yes \_\_\_\_ No \_\_\_\_

**If not, you do NOT need to fill in the following information:**

Injury Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your injuries related to a motor vehicle case (**SGI**)? Yes \_\_\_\_ No \_\_\_\_

**If not, you do NOT need to fill in the following information**

Accident Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy or Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injury Adjustor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RCMP, Veterans Affairs and Military**:**

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note: All accounts are the responsibility of the patient.**

Fee Schedule: Initial Visit $80.00 (First visit or over one year from the last appointment)

Subsequent Visit $50.00

**Consent: I agree and understand that I am responsible for all charges relating to my treatment**.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian (if the patient is under 18 years of age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important: Release of Medical Information**

**Physician Information**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent that \_\_\_\_\_\_\_\_\_\_\_Allay Wellness Centre\_\_\_\_\_\_ may correspond with other healthcare practitioners and diagnostic facilities for the purpose of obtaining pertinent health care information.

* I understand that I may refuse to sign this form, and that my chiropractic care will not be affected if I do not sign this form.

Patient Signature (Legal Guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

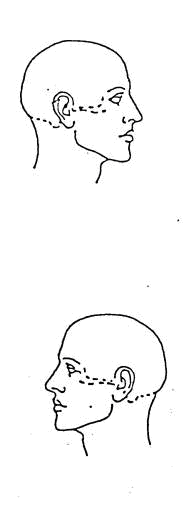
**If the patient’s representative signs this authorization**, please complete the following:

Printed name of representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the diagrams below, please use the symbols below to mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing.

|  |  |  |
| --- | --- | --- |
| Symbols | Numbness ======== | Pins and Needles ooooo |
| Burning x x x x x | Stabbing & Sharp ~~~~ |
| Dull & Aching ∆ ∆ ∆ ∆ ∆ | Stiff & Tight 2 2 2 2 2 |
|  |  |  |



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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please rate the severity of your pain by circling a number below: | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No pain | | | | | Unbearable pain | | | | |
| Have you had this condition in the past? | | | | | | 🌕 Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_  🌕 No | | | |
| Have you seen any other physicians/therapists for this condition? | | | | | | 🌕 Yes, whom? \_\_\_\_\_\_\_\_\_\_\_\_  🌕 No | | | |
| Have you had any imaging (i.e. xray or MRI) for this condition? | | | | | | 🌕Yes, when & where? \_\_\_\_\_\_\_\_  🌕No | | | |

Please use an “” for current conditions and a “” for previous conditions

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **General Symptoms** |  | **Respiratory** |  | **Skin** | |  |
| 🌕 Loss of consciousness | | 🌕 Asthma |  | 🌕 Rashes/itching | |  |
| 🌕 Blackouts |  | 🌕 Chronic cough |  | 🌕 Bruise easy | |  |
| 🌕 Headache |  | 🌕 Spitting up phlegm |  | 🌕 Dryness | |  |
| 🌕 Fever |  | 🌕 Spitting up blood |  | 🌕 Boils | |  |
| 🌕 Excess sweating |  | 🌕 Difficulty breathing |  | 🌕 Hives (allergies) | |  |
| 🌕 Night sweats |  | **Cardiovascular** |  | **Gastrointestinal** | |  |
| 🌕 Loss of weight |  | 🌕 Bleeding disorder |  | 🌕 Poor appetite | |  |
| 🌕 Night pain |  | 🌕 High blood pressure |  | 🌕 Indigestion | |  |
| 🌕 Generalized pain |  | 🌕 Chest pain |  | 🌕 Excess hunger | |  |
| 🌕 Nervousness |  | 🌕 Stroke |  | 🌕 Belching or gas | |  |
| 🌕 Convulsions |  | 🌕 Hardening of arteries |  | 🌕 Vomiting | |  |
| 🌕 Loss of sleep |  | 🌕 Varicose veins |  | 🌕 Pain over stomach | |  |
| **Neurologic** |  | 🌕 Swelling of ankles |  | 🌕 Constipation | |  |
| 🌕 Dizziness |  | 🌕 Poor circulation |  | 🌕 Diarrhea | |  |
| 🌕 Fainting |  | 🌕 Heart/blood disease |  | 🌕 Hemorrhoids (piles) | |  |
| 🌕 Problem speaking |  | 🌕 Angina |  | 🌕 Jaundice | |  |
| 🌕 Problem swallowing |  | **Genitourinary** |  | 🌕 Gall bladder trouble | |  |
| 🌕 Blurred vision |  | 🌕 Trouble urinating |  | 🌕 Intestinal worms | |  |
| 🌕 Double vision |  | 🌕 Blood in urine |  | 🌕 Ulcer | |  |
| 🌕 Nausea |  | 🌕 Kidney infection |  | 🌕 Diabetes | |  |
| 🌕 Clumsiness |  | 🌕 Bedwetting |  | Have you ever had any fractures? | | |
| 🌕 Numbness or tingling |  | 🌕 Prostate trouble |  | 🌕 yes 🌕 no | | |
| **Muscles and Joints** |  | **GU for Women** |  | If yes - where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 🌕 Sore/stiff neck |  | 🌕 Painful menstruation |  | Have you ever been in a car accident? | | |
| 🌕 Mid back ache |  | 🌕 Excessive flow |  | 🌕 yes 🌕 no | | |
| 🌕 Low back ache |  | 🌕 Hot flashes |  | If yes - when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 🌕 Painful tailbone |  | 🌕 Irregular/absent cycle |  | Have you ever been hospitalized? | | |
| 🌕 Shoulder pain |  | 🌕 Cramping/backache |  | 🌕 yes 🌕 no | | |
| 🌕 Arm/forearm pain |  | 🌕 Vaginal discharge |  | If yes- why/when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 🌕 Elbow pain |  | 🌕 Swollen breasts |  | Are you currently a smoker? | | |
| 🌕 Wrist/hand pain |  | 🌕 Lump in breasts |  | 🌕 yes 🌕 no How much? \_\_\_\_\_\_\_\_\_ | | |
| 🌕 Hip pain |  | Currently on birth control pills/patch? | | Did you smoke previously? | | |
| 🌕 Knee pain |  | 🌕 yes 🌕 no | | 🌕 yes 🌕 no How much? \_\_\_\_\_\_\_\_\_ | | |
| 🌕 Ankle/foot trouble |  | Previously on birth control pills/patch? | | Have you ever been diagnosed: | | |
| 🌕 Arthritis |  | 🌕 yes 🌕 no | | With cancer? | 🌕 yes 🌕 no | |
| 🌕 Loss of strength |  | # of pregnancies \_\_\_\_ | | With HIV/AIDS? | 🌕 yes 🌕 no | |
| **Eyes/Ears/Nose/Throat** |  | # of children \_\_\_\_ | | With Hep A/B/C? | 🌕 yes 🌕 no | |
| 🌕 Failing vision |  | **Medications** (list): | | | | |
| 🌕 Eye pain |  |
| 🌕 Failing hearing |  |
| 🌕 Earache |  |
| 🌕 Ring/buzz in ears |  |
| 🌕 Enlarged thyroid |  |
| 🌕 Sinus infection |  |