# 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 ❑?

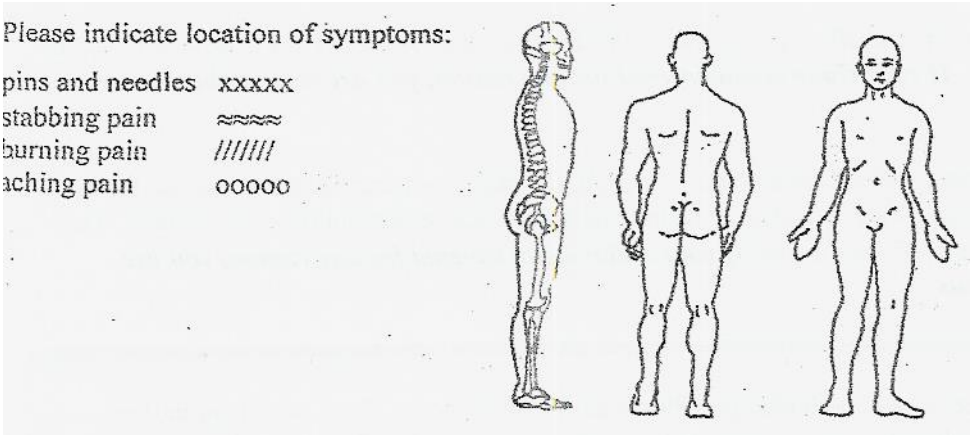
Is your condition getting worse? ____NO ___YES

What makes your symptoms worse?

_____

What helps to lessen your symptoms?

_____




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

_____

Current or recent medication/vitamins: _____

Please Turn Over →

# Confidential Patient Information Form

**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 _____