PERSONAL INFORMATION

Name _____ Date_____

Address _____

City, Province _____ Postal Code _____

Home Telephone _____ Business _____ Cell _____

Email Address: _____ Date Of Birth (d/m/y) _____ Age_____

Health Card #_____ Gender: Male _____ Female _____

Occupation (Your) _____

Employer _____

Address _____

Emergency Contact _____Phone_____

How did you hear about this office: Friend • Phone book • Sign • Other _____

Referred by _____

Prior Chiropractic Care:

Name: _____

Results: Excellent Good Fair Poor

Medical Doctor:

Name: _____ Telephone _____

Address _____

Did your medical doctor recommend that you seek chiropractic care? Yes No

Is it OK if we communicate with your medical doctor regarding your health condition? Yes No

Have any xrays been taken on your spine? Yes No Date:_____

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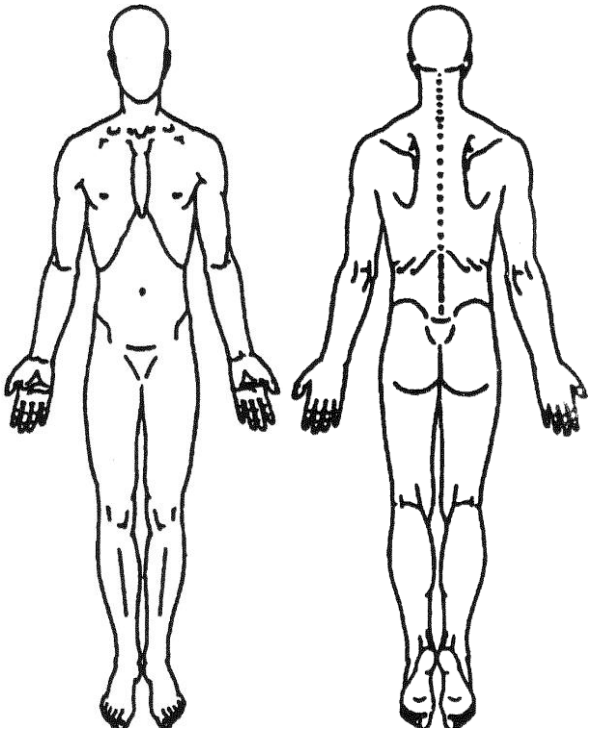
Patient Name: _____ **Date**: _____

Reason for consulting this office: _____

_____

Please indicate on the figures below the areas of your complaint(s) and describe the discomfort using the symbols provided. Please include all affected areas.

Burning X X X X X Aching * * * * * * * Stabbing / / / / / / Pins and Needles 0 0 0 0 Numbness ● ● ● ●



When did this problem begin? _____ How did it occur?_____

What makes this condition worse? _____

What makes it better? _____

Is the problem getting better, worse or staying the same?_____

Does the pain radiate? Yes / No If yes, where does the pain travel? (i.e. down the arm, down the leg, etc)

_____

When does it bother you the most? (morning, evening, driving to work, after exercise, etc.)

_____

Have you ever been diagnosed with any of the following?

High blood pressure	Y N	
High cholesterol	Y N	
Diabetes	Y N	
Heart Disease	Y N	
Cancer	Y N	If yes, what type? _____
Whiplash	Y N	
Double vision or partial loss of vision	Y N	
Slurred speech or difficulty swallowing	Y N	
Dizziness	Y N	
Loss of consciousness	Y N	
Numbness or weakness in any part	Y N	If yes, where? _____
Do you suffer from migraines?	Y N	
Do you take oral contraceptives?	Y N	

Do you have a family history of (please check)?

- Cancer
- Diabetes
- Heart Conditions
- Arthritis
- Stroke

Other:_____

Lifestyle

Do you do weightbearing exercises? Yes / No If yes, how often? _____

Do you do cardiovascular exercises? Yes / No If yes, how often? _____

Do you drink alcohol? • Yes / No If so, how many drinks per week? _____

Do you smoke? Yes / No If yes, how many per day or week? _____

Have you had any prior surgeries? Yes / No _____

Have you had any prior hospitalizations? Yes / No _____

Have you had any broken bones? Yes / No _____

Sleep (hours per night): 4-6 6-8 8-10 12+ Is it solid sleep? • Yes / No

What position do you sleep in? Side / Stomach / Back / All over

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Rate your diet: Poor Fair Good Excellent Meals per day: _____

Do you take vitamins and/or minerals? • Yes • No If yes, please list: _____

Please list any medication(s) you take on a regular basis: _____

What is your current height? _____ Weight? _____

Do you use a computer for long periods at work? Yes / No

I hereby authorize the health care professionals at Hammonds Plains Chiropractic to release or obtain any health information from my other health care providers as may be required for the management of my case.

I have read and understood the Hammonds Plains Chiropractic fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf, I am responsible for any outstanding balance not covered by my insurance policy.

Patient Signature: _____ Date: _____

Hammonds Plains Chiropractic Fee Schedule and Cancellation Policy

Chiropractic Services

Initial Chiropractic Consultation	$85
Subsequent Chiropractic Treatment	$45
Subsequent Acupuncture (includes chiropractic treatment, if required)	$65

Children and Students

Initial Chiropractic Consultation	$70
Subsequent Chiropractic Treatment	$40
Subsequent Acupuncture (includes chiropractic treatment, if required)	$55

Orthotics

Custom Orthotic Inserts	$300
Custom Orthotic Shoes	$440

Hours of Operation:

Monday 8:30am – 7pm

Tuesday 3:30pm – 7pm

Wednesday 8:30am – 5pm

Thursday 10am – 7pm

Friday 8:30am – 12pm

- Please note there is a fee for missed appointments and those cancelled with less than 24 hours notice. This is a personal charge that will not be billed to your insurance company. We ask that you please provide a minimum of **24 hours notice** for cancelling an appointment.
- All payments for services are due at the time of the scheduled appointment.
- Those patients whose insurance companies allow for direct billing are required to pay the remaining balance at the time of each visit, if applicable.

I have read, understood and agreed to the above terms and policies.

Patient Name: _____ Signature: _____ Date: _____