PATIENT ENTRANCE FORM

(PLEASE PRINT)

Name _____ Date _____

Address _____ City _____

Province _____ Postal Code _____ E-mail _____

Home Tel _____ Work phone _____ Cell phone _____

Date of Birth (D/M/Y) ____/____/_____ Age _____ Sex M / F Martial Status – S M D W

Weight _____Height _____ Occupation _____ Pregnant? _____

Spouse's or Parent's Name _____ No. of children _____

Who may we thank for referring you to our office? _____

Have you ever had Chiropractic Care before? Yes / No If so, when? _____

List your complaints according to severity of pain:

1. _____ 2. _____

3. _____ 4. _____

Contact information of your family doctor:

Name _____ Address/Phone _____

Other Doctor(s) seen for the above conditions:

1. Name _____ Address/Phone _____ When? _____

2. Name _____ Address/Phone _____ When? _____

Are you taking any medication? Yes / No What kind? _____

_____

Please list ANY previous surgeries, falls or accidents you may have had in the past:

_____

_____

Check the following conditions you may have had or do have now:

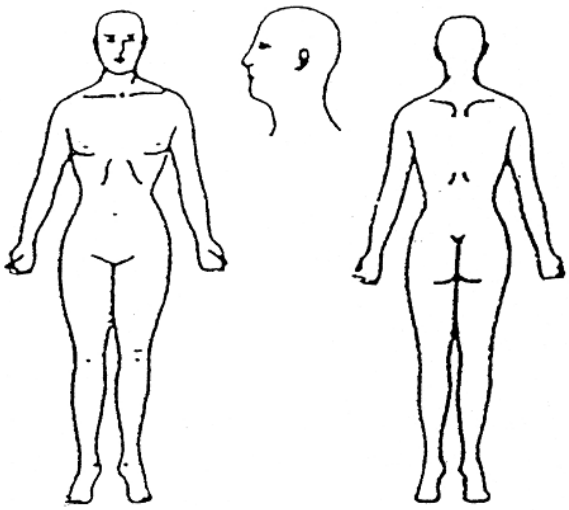
☐	Allergy	☐	Gout	☐	Neck Pain/Stiffness
☐	Arthritis	☐	Headaches	☐	Numbness or pain in arms/legs/hands
☐	Back Pain/Stiffness	☐	Heart Disease	☐	Ringing in ears
☐	Cancer	☐	Heart Attack	☐	Sinus Problems
☐	Diabetes	☐	High Blood Pressure	☐	Spinal curvature
☐	Dizziness	☐	Low Blood Sugar	☐	Stroke
☐	Chronic Fatigue	☐	Migraines	☐	Others _____

[Please turn over]

Please place a vertical mark on the line below to rate your pain:

0 — 0 (no pain) to 10 (extreme pain) — 10

Please mark the area(s) of the body where you do not feel well



Notice to patient:

1. Cancellation/ No Show Policy

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. ***If an appointment is not re-scheduled/cancelled <u>at least 24 hours</u> in advance you will be charged a forty-dollar ($40) fee; this will not be covered by your insurance company.***

2. Refund Policy

   Any service (such as consultation, examination, treatment, shipping & handling, etc.) rendered is not eligible for refund.
   Dietary supplement, health and personal care items (such as pillow) is not eligible for refund.

3. In this clinic, as a service to you, also provides additional services and products, including but not limited to acupuncture, massage therapy, nutritional consultations, dietary supplements, custom-made orthotics, fat burning & detox programs and personal training programs. The above services and products are recommended according to individual needs.

You are under no obligation to use or purchase the above services and products at our clinic. In addition, regardless whether you prefer to use our additional services/products or not, you nevertheless have the best of our care.

I, _____ have read and understand the above statements.
(Print Name)

Signature _____ Date _____