PATIENT INFORMATION SHEET
(Please Print Clearly)

How do you wish to be addressed in our office?
( )First Name ( )Mr. ( )Mrs. ( )Miss ( )Ms. ( )Dr.

NAME: ______________________

ADDRESS: ______________________
CITY: ______________________
POSTAL CODE: ______________________

EMPLOYED BY: ______________________
ADDRESS: ______________________
OCCUPATION: ______________________

PHONE (H): ______________
PHONE (O): ______________
Extension: ______________
CELLULAR: ______________
FAX: ______________

DATE OF BIRTH: ______________
D / M / Y

MARITAL STATUS: ______________
CHILDREN: ______________________
(Names & Ages) ______________________
____

SPOUSE'S NAME: ______________
OCCUPATION: ______________
PHONE (O): ______________
Extension: ______________

PARENTS (If patient is a minor) Father ______________ Mother ______________

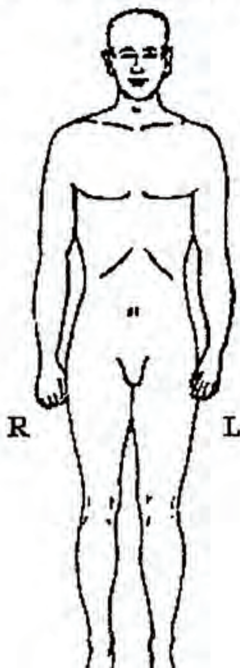
REFERRED BY: ______________________
MEDICAL DOCTOR: ______________________

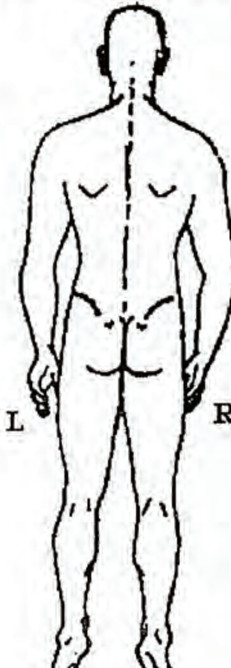
What is the nature of your problem? ______________________

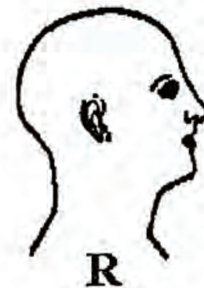
Have you had previous chiropractic care? If so, by whom? When?
____

Have you ever been hospitalized and/or had any surgery? Dates & details:
____
____

PLEASE SHADE YOUR AREAS OF PAIN ON THE FIGURES BELOW







EYES

___ Pain
___ Blurring
___ Bothered by light
___ Infection
___ Loss of vision
___ Cataracts
___ Other ________________

MOUTH

___ Bite plate for TMJ
___ Gum disease
___ Bleeding gums
___ Swollen gums
___ Painful gums
___ Change in taste
___ Other ________________

MEDICATIONS

(Regularly taken or prescription)

___ Insulin
___ Antacids
___ Heartburn remedies
___ Laxatives
___ Water pills
___ Aspirin
___ Muscle relaxers
___ Tranquilizers
___ Blood pressure pills
___ Birth control pill
___ Mega-doses vitamins
___ Pain killers
___ Nerve pills
___ Pep pills
___ Narcotics
___ Other ________________

EARS

___ Pain
___ Hearing loss
___ Ringing in ears
___ Discharge from ears
___ Infections
___ Other ________________

SKIN

___ Rashes
___ Colouration changes
___ Lumps
___ Bruise easily
___ Other ________________

NOSE

___ Discharge
___ Sinus problems
___ Other ________________

CHILDHOOD DISEASES

___ Measles (Rubeola)
___ Mumps
___ Chickenpox (Varicella)
___ German measles (Rubella)
___ Whooping cough (Pertussis)
___ Scarlet fever
___ Rheumatic fever
___ Diptheria
___ Polio
___ Hip joint disease
___ Other ________________

ALLERGIES

___ Food ________________
___ Feathers
___ Flowers & plants
___ Animals
___ Dust & pollen
___ Other ________________

THROAT

___ Hoarseness
___ Frequent sore throats
___ Other ________________

___ Do you wear heal lifts, arch supports or any other orthotic device?

___ Have you ever had cancer?

___ Do you smoke?

How often do you consume alcoholic beverages? ________________

dditional information: ________________

GENERAL HEALTH QUESTIONNAIRE

Please indicate which of the following apply.

✓ FOR PRESENT PROBLEM X FOR PAST PROBLEM

MUSCULO-SKELETAL

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm pain
____ Swollen joints
____ Leg pain
____ Stiff joints
____ Muscle cramps
____ Muscle weakness
____ Walking problems
____ Ruptures (hernias)
____ Broken bones or fractures
____ Dislocations
____ Bone diseases
____ Other ____________

NERVOUS SYSTEM

____ Inco-ordination
____ Tremors
____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Frequent headaches
____ Muscle twitching
____ Convulsions/Seizures
____ Forgetfulness
____ Confusion
____ Depression
____ Other ____________

GASTRO-INTESTINAL

____ Poor appetite
____ Excessive appetite
____ Difficulty swallowing
____ Excessive thirst
____ Heartburn
____ Excessive gas
____ Excessive bleeding
____ Frequent nausea
____ Frequent vomiting
____ Vomited blood
____ Ulcers
____ Irregular bowel movements
____ Intestional infections
____ Indigestion
____ Red or tar coloured stools
____ Hemorrhoids
____ Frequent diarrhea
____ Frequent constipation
____ Weight trouble
____ Diabetes
____ Other ____________

GENITO-URINARY

____ Irregular urination
____ Painful urination
____ Bladder infection
____ Excessive urination
____ Scanty urination
____ Discoloured urine
____ Unable to hold urine
____ Kidney stones
____ Other ____________

RESPIRATORY

____ Constant cough
____ Excessive phlegm (sputum)
____ Coughing up blood
____ Wheezing
____ Asthma
____ Frequent bronchitis
____ Other ____________

CARDIO-VASCULAR

____ Chest pain
____ Racing heart beat
____ Swelling of feet or ankles
____ Varicose veins
____ Fainting spells
____ Blood pressure problems
____ Cramps in legs
____ Poor circulation
____ Jaundice
____ Anemia
____ Stroke
____ Other ____________

FEMALES ONLY

____ Menopause
____ Discharge from nipple
____ Lumps in breast
____ Breast pain
____ Vaginal discharge
____ Abnormal menstruation
____ Painful periods
____ Contraceptives
____ Pregnancies (Number)
____ Other ____________

SCOTIA CHIROPRACTIC HEALTH CENTRE INC.
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579 Sackville Drive
Lower Sackville, Nova Scotia B4C 2S4
Tel.: (902) 864-4411 Fax: (902) 864-3313

General Information

If a new condition arises or if you change your address, phone number, or place of work, please advise the clinic staff as soon as possible.

In consideration of our patients, as well as our staff, we ask that you please refrain from wearing perfume, cologne or aftershave when you come for your appointments with us.

Account Information

The provincial health care plan in Nova Scotia (MSI) does not cover Chiropractic health services. Therefore, payment is due at the time of your appointment, unless other arrangements have been made. Fees for Chiropractic health care services are as posted in the reception area and are subject to change without notice. Patients are invited to use cash, debit, Visa and Mastercard to keep their accounts current. Please discuss the fees of the clinic with Dr. Richard if you have any concerns.

If you have coverage through your personal health insurance company plan, or any other third party, you are directly responsible for the program. Receipts are issued at the time of payment and can be used for reimbursement from your particular plan.

In event of coverage resulting from a work related injury, a Workers' Compensation Board (WCB) claim number and confirmation of coverage must be obtained to proceed with direct billing. If not provided, or if the claim has not yet been approved, you will be personally responsible for all fees billed to your account. Once the claim is approved, it is your responsibility to advise the Clinic staff of this. It is also your responsibility to submit your receipts for any treatment rendered prior to providing the Clinic staff your claims number, to the WCB for reimbursement of the portion covered by the WCB. Any subsequent treatments would be billed directly to the WCB.

In the event of coverage resulting from a motor vehicle accident or personal injury claim, confirmation of coverage, including the policy number, must be obtained from the insurance company, to proceed with direct billing. If required, requests for letter or medical –legal reports must be made in writing and may not be released until payment is received.

In an effort to better serve our patients, 24 hours notice of cancellation is required. In the event of a missed appointment or insufficient notice of cancellation, the fee for a late appointment will be billed to your account. Please note that insurance companies do not cover missed appointments.

If you are discharged or discontinue treatment, any balance on your account is immediately due and payable.

I have read , understand and agree to the policies described above. I have also had an opportunity to ask questions about these policies. I also understand that these policies may be subject to change without notification.

Signature____ Date ______________________

(If patient is a minor, parent or guardian must sign)