Chiropractic Associates of Port Colborne

(ADULT HISTORY FORM)

It is a pleasure to welcome you to our family of happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you on your road to better health.

Date:______________________________

Name:______________________________

Address:______________________________

City:______________________________

Postal Code:______________________________

E-Mail:______________________________

Full Name on Health Card:

____

Please check the type of care desired.

☐ Temporary Relief ☐ Lasting Correction

☐ Check here if you want the doctor to select the type of care he feels is best for you.

Date of Birth:______________________________

Home Phone Number:______________________________

Business Number:______________________________

Health Card Number:______________________________

Version Code:______________________________

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Name of Spouse:______________________ Ages of Children:______________________

Where are you or your spouse employed:______________________________

Your days off:______________________ Referred to our office by:______________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Other:______________________

How will payment be made: ☐ Cash ☐ Cheque ☐ Interac Bank Name:______________________

☐ Visa ☐ Mastercard Bank address:______________________

Is this complaint resulting from a car accident? ☐ Yes ☐ No

Is this a worker's compensation case? ☐ Yes ☐ No

If **YES** Social Insurance Number:______________________________

Date of Accident:______________________________

Claim Number:______________________________

Name and Address of Employer:______________________________

____

Major complaint (please describe only your major complaint):______________________________

____

____

How did this condition develop (What caused it? How did it start?):______________________________

____

When was the first time you were aware of this problem?______________________________

____

Have you ever had this problem or similar before? If yes explain:______________________________

____

Have you recently received any treatment for this condition? If yes where and when and what were the results?:__________

____

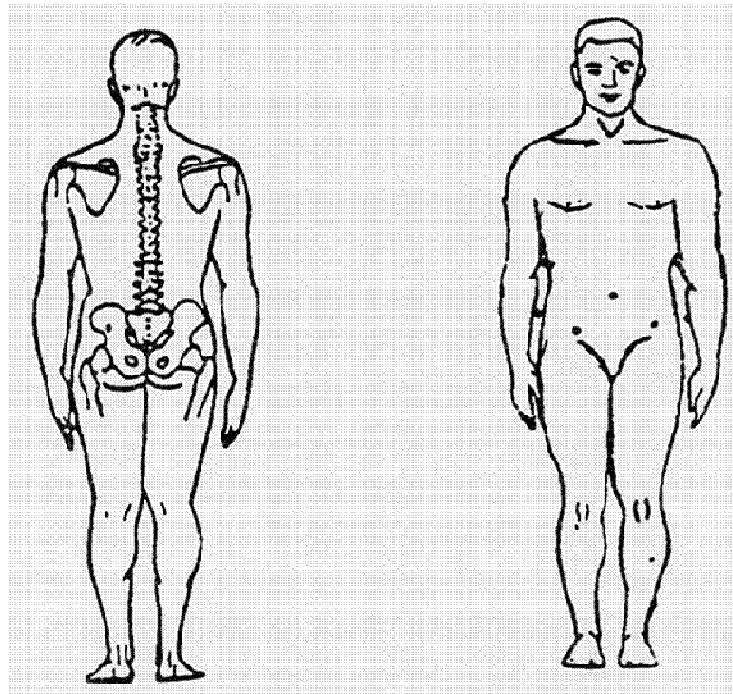
____

Has this problem been getting ☐ better ☐ worse ☐ staying the same. Is there anything that you do that makes your condition worse?

____

____

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF PAIN ON THIS DIAGRAM.



HOW HAS THIS CONDITION AFFECTED YOUR LIFE:

A) Home Life:____________________

B) Occupational Life:____________________

C) Recreational Life:____________________

D) Rest and Sleep Life:____________________

Have you ever been involved in an automobile accident? ☐ past year ☐ past five years ☐ over five years ☐ never

Any accidents, falls, etc. That might have caused you problem?____________________

____

Any medical diagnosis of your complaint?____________________

What surgery has been done?____________________

Drugs you now take: ☐ nerve pills ☐ pain killers ☐ muscle relaxers ☐ pep pills ☐ tranquilizers ☐ insulin ☐ birth control pills ☐ other:____________________

Any chiropractor consulted in the past? Name: Dr.____________________

Date consulted____________________For what problem____________________

Fees are payable at the time examinations and treatments are received, unless other arrangements are made in advance.

Patient's/Guardian's Signature:____________________Date:____________________

"committed professionals with a goal of helping you return to a natural state of good health."