STUART CHIROPRACTIC

A B C D

CONFIDENTIAL PATIENT INFORMATION

Patient Information:

Name:* (First) _____(Nickname) _____ (Last)* _____ DOB*: (MM/DD/YY) ____ /____ / ___

Address*: _____

City*: _____ Province*: _____ Postal Code*: _____

Home Phone* #: (____) _____ or Cell* #: (____)_____

E-mail*: _____ Care Card #: _____

Gender*: M/ F/ Non-binary / Not listed Gender Pronouns: _____ Height: _____Weight:_____

Name of Spouse/Partner or Guardian? _____ Names of Children: _____

Patient Employment:

Occupation*: _____

Employer's Name: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Initials* _____ I give permission for you to communicate clinical information relevant to my care at this office with my medical doctor _____.

Initials *_____ I grant permission to be called to reschedule an appointment; and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office, appointment reminders, and/statements.

Initials *_____ I grant permission for my extended health insurance to be electronically submitted on my behalf.

Please Specify:		
Statements: □ Electronically Sent	*□ Printed*	*□ No Statement/Only When Requested*
Appointment Reminders: □ Email	*□ Text Message*	*□ No Reminder*

Reason(s) for your visit:

List your problems or complaints according to severity of pain	Date started, or for how long?	If you had the condition before, when?	Did the problem begin with an injury?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Other doctors seen for this condition?

Medical Dr. _____
Other Dr. _____

How is this condition affecting you? _____

How many hours of sleep? _____

What aggravates your condition? _____

Review of Past Care

Are you taking any medications?	Yes ☐	No ☐	What kind? _____
Have you had any X-rays , MRI/CT-Scans done?	Yes ☐	No ☐	Where? _____ When? _____
Are you a Smoker (Cigarettes/Recreational)?	Yes ☐	No ☐	Specify Type: _____ Frequency?_____
Were you in any accidents/injuries?	Yes ☐	No ☐	Auto_____ Claim #: _____ Work _____Other _____
Have you had any surgeries?	Yes ☐	No ☐	What kind? _____

Patient Medical History:

C – Current Issue **P** – Past Issue

_____	Alcoholism	_____	Epilepsy	_____	Miscarriage
_____	Anemia	_____	*Abdominal Pain*	_____	Multiple Sclerosis
_____	Asthma	_____	Gout	_____	Anxiety
_____	*Cancer*	_____	*Heart Attack*	_____	Ringing in Ears
_____	*Heart Disease*	_____	Sinus Problems/Allergy		
_____	*Depression*	_____	*High Blood Pressure*	_____	*Stroke*
_____	*Diabetes*	_____	*Irregular Menstruation*	_____	Thyroid _____ ADHD
_____	*Menstrual Cramps*	_____	Ulcers	_____	**Other**

Patient's signature: _____ Date _____

Techs Notes:

_____

_____

_____

_____

Tech's signature: _____ Date: _____

ICBC Only:

Work Status

1. IS THE PATIENT STILL JOB ATTACHED?
○ Yes ○ No

2. IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

3. HAS THE PATIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ○ Yes ○ No Training: ○ Yes ○ No School/Studies: ○ Yes ○ No

If the patient is continuing to work, study or train indicate their status, as applicable

4. STATUS OF DUTIES
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

5. STATUS OF HOURS
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified