D I S C

STUART CHIROPRACTIC

Tx:

Patient Information:

Name:* (First) _____**(Nickname)** _____ **(Last)*** _____

Address*: _____ **DOB*: (MM/DD/YY)** ____ /____ / ____

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

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

E-mail*: _____ Care Card #: _____

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

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 CHOOSE WHAT YOU PREFER:			
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. _____	_____	_____	_____

☐Dx ☐TY ☐TC
☐Dr ☐MC ☐ND
☐CS ☐ICBC ☐S2F

Review of Past Care

Are you taking any medications for this pain?	Yes ☐	No ☐	What kind? _____
Have you had any X-rays , MRI/CT-Scans done?	Yes ☐	No ☐	Where? _____ When? _____
Were you in any accidents/injuries?	Yes ☐	No ☐	Claim #: _____
Have you had any surgeries?	Yes ☐	No ☐	What kind? _____
Have you seen anyone else for this condition?	Yes ☐	No ☐	Where? _____

Patient Medical History:

C – Current Issue **P** – Past Issue

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

What is your **Pain level** on a scale from 1 – 10? _____

Techs Notes:

Print or email completed forms to **office@stuartchiropractic.com**
Thank you. We look forward to seeing you!