









Patient Information:

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 Date started, or for If you had the condition Did the problem begin with according to severity of pain how long? before, when? an injury? 1 2 3	Name:* (First)	(Nickname)	(Last)*			
Home Phone* #: (Address*:		DOB*: (MM)	'DD/YY)//		
E-mail*: Care Card #:	City*:	Province*: _	Postal Code	*:		
Gender*: M/F/ Non-binary / Not listed Gender Pronouns:	Home Phone* #: ()	or	Cell* #: ()			
Name of Spouse/Partner or Guardian?	E-mail*:		Care Card #:			
Patient Employment: Occupation*:	Gender*: M/ F/ Non-binary / Not li	sted Gender Pronouns	:			
Occupation*: Employer's Name: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? Initials*	Name of Spouse/Partner or Guardia	an?	Names of Children: _			
Employer's Name:	Patient Employment:					
Employer's Name:	Occupation*:					
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						
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according to severity of pain how long? before, when? an injury? 1	Reason(s) for your visit:					
1	List your problems or complaints	Date started, or for	If you had the condition	Did the problem begin with		
2	according to severity of pain	how long?	before, when?	an injury?		
2						
3	1					
□Dx □TY □TC □Dr □MC □ND	2					
□Dr □MC □ND	3					
	□Dx	□TY		□ТС		
□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?	
atient Medical History:				
atient Medical History: C – Current Issue		st Issue		
atient Medical History:		st Issue Diabetes	*	 Multiple Sclerosis
c – Current Issue			*	 Multiple Sclerosis Sinus Problems/Allergies
C – Current Issue Abdominal Pain	[Diabetes	*	
C – Current Issue Abdominal Pain ADHD	! !	<i>Diabetes</i> Epilepsy		 Sinus Problems/Allergies
C – Current Issue Abdominal Pain ADHD Alcoholism*	! !	Diabetes Epilepsy Gout	tack	 Sinus Problems/Allergies Stroke*
atient Medical History: C – Current Issue Abdominal Pain ADHD Alcoholism* Anemia*	! ! !	Diabetes Epilepsy Gout Heart Att	tack	 Sinus Problems/Allergies Stroke* Thyroid
atient Medical History: C – Current Issue Abdominal Pain ADHD Alcoholism* Anemia* Anxiety*	! ! !	Diabetes Epilepsy Gout Heart Att Heart Dis	tack sease*	 Sinus Problems/Allergies Stroke* Thyroid