Lifeforce Proactive
HEALTH CENTRE

Re-Admission Form

Providing the most accurate information as possible related to your condition will greatly assist us in recommending the most effective *Treatment Program*

Date: _____ Case #: _____

First Name: _____ Last Name: _____

Birth Date: M ____ D ____Y ____ Age _____

E-Mail Address for Appointment Reminders: _____

The following personal information only needs to be completed if it has changed since your last visit

Address: _____ City: _____

Province: _____ Postal Code: _____ Care Card #: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Employer: _____ Type of Work: _____

Is this visit a result of a Motor Vehicle Accident or Worker's Compensation Injury? ■ Yes ■ No

If yes, please advise the receptionist for the appropriate forms.

CURRENT HEALTH HISTORY

- Previous Chiropractic Care (Dr's name and date of last treatment): _____
- Purpose of this Appointment? _____
- What is your primary complaint? _____
- When did this condition begin? _____
- Is your condition getting better, worse or staying the same? _____
- What aggravates your condition? _____
- What relieves your condition? _____
- Are there others in your family with this same condition? ■ Yes ■ No
- How many recurrences of your symptoms have you had since your last visit to our office? _____
- Medication you are taking now ■ Nerve pills ■ Pain Killers/Muscle Relaxers ■ Blood Pressure ■ Insulin ■ Aspirin/Similar ■ Other _____

  If yes, for what condition? _____
- Major Surgery / Operations _____
- Major accidents or Falls _____
- Hospitalization (other than above) _____

PLEASE INDICATE IF YOU WOULD LIKE INFORMATION ON ANY OF THE FOLLOWING:

■ LaserCare Therapy ■ Custom Orthotics ■ Bone Density Testing
■ Massage Therapy ■ Body Composition ■ Exercise Specialist