CLAYTON PARK CHIROPRACTIC CENTRE INC.

11-117 KEARNEY LAKE ROAD, HALIFAX, NS B3M 4N9 PHONE: 902-443-5669 FAX: 902-443-9419 EMAIL: INFO@CLAYTONPARKCHIRO.CA.

For office use only:

Bilaterals: L____ R____

H:_____ W:_____

Name: _____

Date: _____

Address: _____ City: _____

Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

We offer text reminders for your appts. If interested, who is your cell phone provider? _____

Email Address: _____ Sex: Male___ Female___

Date of Birth: _____ Age: _____ Pregnant? Yes___ No___ No. Of Children_____

Marital Status: (circle) Married Single Widowed Divorced Separated Other

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

Who may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

What is your primary complaint? _____

Have you seen a chiropractor before? _____ If yes, when? _____

Check all symptoms you have ever had even if they don't seem related to your current problem.

	Headaches		**Pins and needles in legs**		**Neck pain**		**Dizziness**
	Migraines		**Back pain**		**Loss of balance**		**Fatigue**
	Pins and needles in arms		**Numbness in fingers**		**Numbness in toes**		**Cold Feet/Hands**
	Ringing in ears		**Tension**		**Menstrual irregularity**		**Convulsions**
	Depression		**Neck stiffness**		**Heartburn**		**Vertigo**
	Sleeping problems		**Problem urinating**		**TMJD**		**Shoulder Pain**
	Stroke		**Asthma**		**Ankle Swelling**		**Ear Aches**
	Chest Pain		**Short Breath**		**High/low blood pressure**		**Irregular Heartbeat**

Please list any medications and supplements you are taking: _____

_____

If this is due to a work injury or auto accident, what was the date of the injury or accident?_____

_____

Has this problem been getting worse, better, or staying the same? _____

What activities aggravate your condition? _____

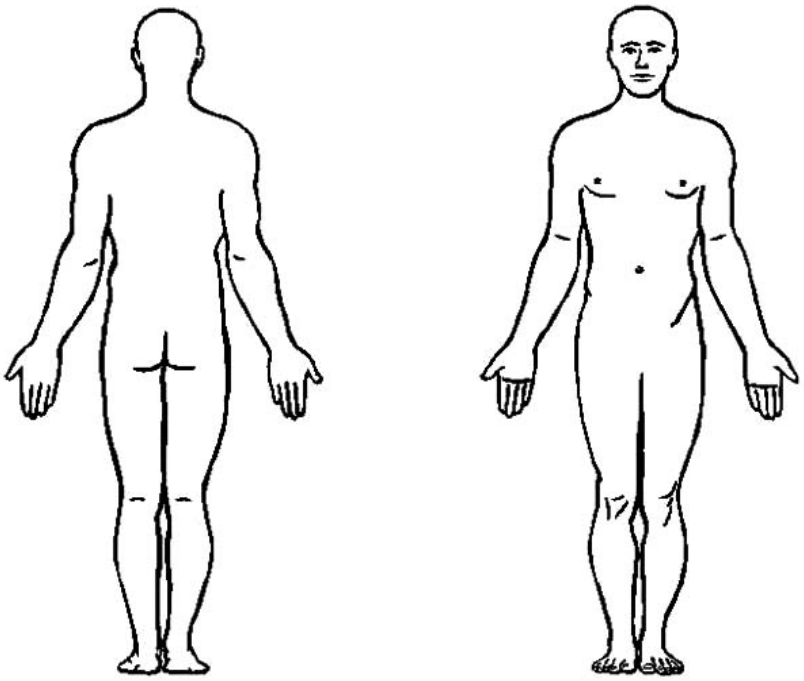
Any surgeries or hospitalizations? _____

Injuries or illness that you have not listed above: _____

Any X-rays or any other imaging taken? _____

In the diagrams below, please mark the areas on your body which you feel best represents the pain(s) or sensation(s) that you experience. Please include all areas. <u>Use the symbols provided below.</u>

Numbness	=
Pins and Needles	**
Burning	xx
Sharp & Stabbing	//
Dull & Aching	++
Stiff & Tight	^^



<u>Chiropractic Services:</u>

Consultation (10 min)	Free
Initial Chiro Exam	$100.00
Chiro Adjustment	$59
Acupuncture + Chiro Adjustment	$94
Chiro Re-Assessment	$69
Missed Appointment Charge	**$45.00**

<u>Registered Massage Therapy Services:</u>

1/2 Hour Session	$65.00
1 Hour Session	$100.00
1 ½ Hour Session	$155.00
2 Hour Session	$200.00

<u>Kinesiologist, Personal Trainer, Holistic Lifestyle Coach:</u>

Kinesiology	15-30 min sessions
Personal Training	60 min sessions
Holistic Lifestyle Coaching	30-60 min sessions

IF LESS THAN 24 HOURS NOTICE IS GIVEN TO CANCEL MASSAGE THERAPY/KINESIOLOGY A FULL APPOINTMENT FEE WILL BE CHARGED

<u>NO DIRECT BILLING:</u> Our office does <u>NOT</u> direct bill to any insurance company therefore **PAYMENT IN FULL IS DUE** on the date of service. (We accept exact cash, cheque, debit, visa or master card)
This office is **<u>scent sensitive</u>**. Please refrain from wearing strong perfumes and aftershaves during your visit.

I, (printed name) _____ have read and I understand the above policies.

_____ _____

Patient Signature (or guardian) **Date**