Chiropractic Associates of Port Colborne

(Adult History Form)

It is a pleasure to welcome you to our family of happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you on your road to better health.

Date: _____
Name: _____
Address:_____
City: _____
Postal Code: _____
E-mail:_____
Full name on Health Card:
_____
Health Card Number:_____

Please check the type of care desired.

❑ Temporary relief ❑ Lasting correction
❑ Check here if you want the doctor to select the type of care he feels is best for you.

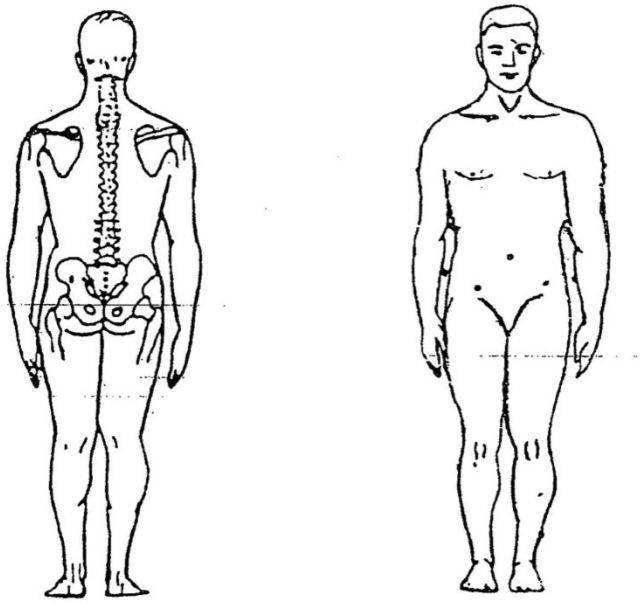
Date of Birth: _____
Day Month Year
Place of Birth: _____
Home Phone Number:_____
Cell Number: _____
Version Code: _____

Check if you are: ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced
Name of Spouse: _____ Ages of Children: _____
Where are you or your spouse employed: _____
Your days off: _____ Referred to our office by: _____
Who is responsible for your bill?: ❑ Self ❑ Spouse ❑ Employer ❑ Other:_____
How will payments be made?: ❑ Cash ❑ Cheque ❑ Interac ❑ Visa ❑ MasterCard
Bank Name: _____ Address: _____
Is this complaint resulting from a car accident: ❑ Yes ❑ No
Is this a worker's compensation case? ❑ Yes ❑ No
If YES Social Insurance Number: _____
Date of Accident: _____
Claim Number: _____
Name and Address of Employer: _____
_____

Major complaint (please describe only your major complaint):
_____
_____
_____
How did this condition develop? (What caused it, how did it start):
_____
_____
When was the first time you were aware of this problem?:
_____
Have you ever had this problem or similar before? If yes, explain:
_____
Have you received any treatment for this condition? If yes, where, when, and what were the results?:
_____
_____
Has this problem been getting ❑ Better ❑ Worse ❑ Staying the same
Is there anything you do that makes your condition worse?:
_____
_____

CONTINUED ON REVERSE

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF PAIN ON THIS DIAGRAM



How has this condition affected your life:

A) Home life:_____

B) Occupational life:_____

C) Recreational life: _____

D) Rest and sleep life: _____

Have you ever been involved in an automobile accident? ❑ past year ❑ past five years ❑ over five years ❑ never

Any accidents, falls, etc. that might have caused your problem?

_____

_____

Any medical diagnosis of your complaint?: _____

What surgery have you done?: _____

Drugs you take now: ❑ nerve pills ❑ pain killers ❑ muscle relaxers ❑ pep pills ❑ tranquilizers
❑ insulin ❑ birth control pills ❑ other:_____

Any chiropractor consulted in the past? Name: Dr._____

Date consulted: _____ For what problem: _____

Have you been to another chiropractor since last April 1st?: _____

Number of visits since April 1st:_____

Fees are payable at the time examinations and treatments are received, unless other arrangements are made in advance.

Patient's/Guardian's Signature: _____ Date: _____

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(905) 835-1303
www.chiropracticassociates.com