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:

_____

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:_____

Home Phone Number:_____

Business Number:_____

Health Card 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 payment be made: ☐ Cash ☐ Cheque ☐ Interac ☐ Visa ☐ Mastercard

Bank Name:_____

Bank 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 recently received any treatment for this condition? If yes where and when and what were the results?:_____

_____

_____

Has this problem been getting ☐ better ☐ worse ☐ staying the same. Is there anything that you do that makes your condition worse?

_____

_____

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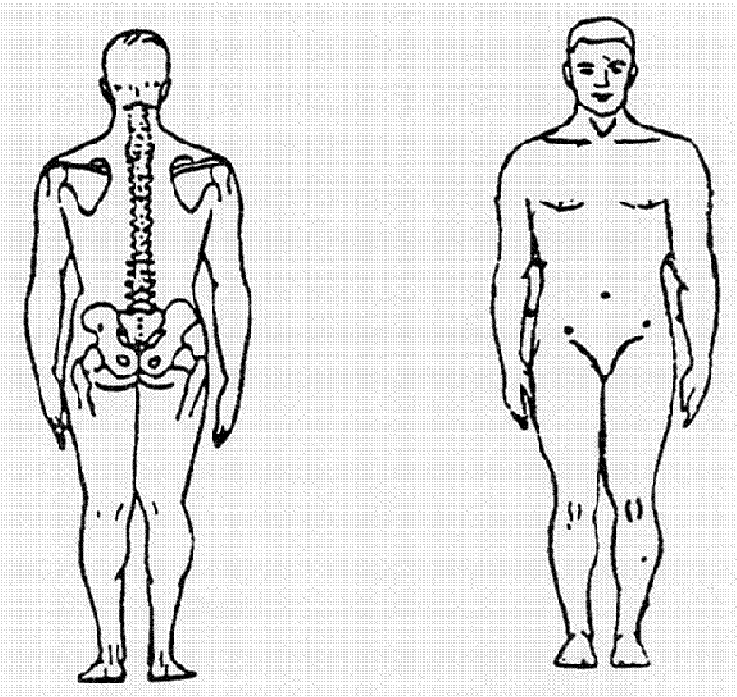
IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF PAIN ON THIS DIAGRAM.



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 you problem?_____

_____

Any medical diagnosis of your complaint?_____

What surgery has been done?_____

Drugs you now take: ☐ 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_____

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

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

"committed professionals with a goal of helping you return to a natural state of good health."

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