Barrie South Chiropractic Centre
Dr. Hans G. Teschl, B.Sc., D.C.

190 Minet's Point Road
Barrie, Ontario L4N 4C3

PATIENT INTRODUCTION

NAME: ______________________________________ DATE OF BIRTH (D/M/Y): ________________

AGE: ________ SEX:________ REFERRED BY: ____

ADDRESS: ________________________________ CITY: ______________POSTAL CODE: ________

TEL: HOME: (____)______________________ BUS: (____)____________________ EXT: _________

OCCUPATION: ________________________________ EMPLOYER: _________________________

MARITAL STATUS : S / M / SEP / D / W NUMBER OF CHILDREN: ________

E-MAIL ADDRESS:_____________________________________

Will any claim be made against:

1. Recent motor vehicle accident : No Yes - (if yes, complete MVA Form)
2. Work related injury/accident : No Yes - (if yes, complete WSIB Form)

In either case, if your claim is rejected, you are responsible for all charges.

Details of problem:

Use the appropriate symbols to mark the areas on the body where you feel the described sensations. Include areas of radiation. <u>Please indicate the duration of each complaint</u>.

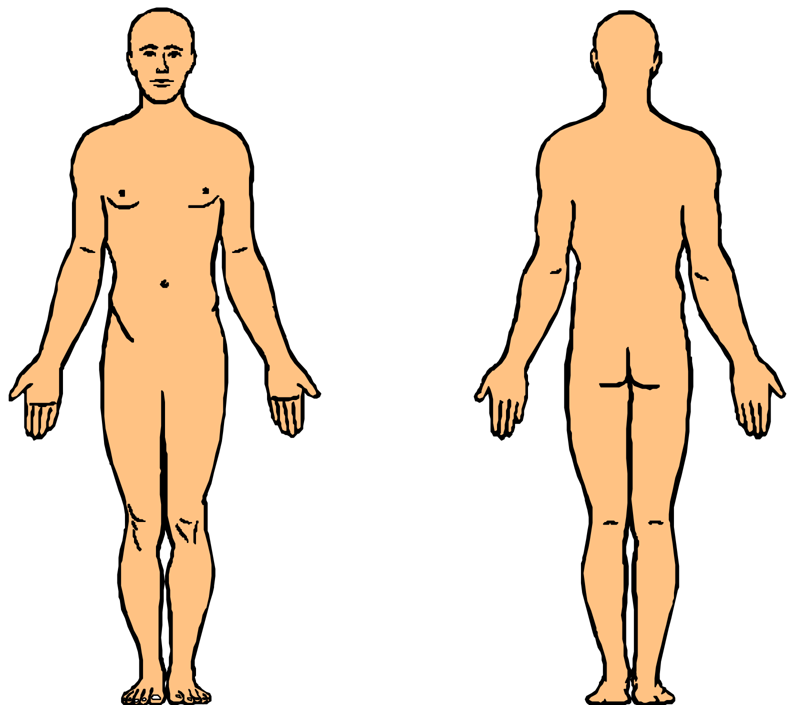
Numbness: • • • • •
• • • • •
• • • • •

Pins and Needles: o o o o
o o o o
o o o o

Burning: X X X X
X X X X
X X X X

Aching: * * * * *
* * * * *
* * * * *

Stabbing: / / / / /
/ / / / /
/ / / / /



Patient Name____ File No:__________

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Previous Chiropractor:

Name: ____

City: ___________________________________ Date of Last Appointment: _________________

Medical Doctor:

Name: ____

City: ___________________________________ Date of Last Appointment: _________________

Is there any history of the following:

Osteoporosis _____ Arthritis ______ Cancer _______ Heart Condition _____ High Blood Pressure _____

Migraine Headache ______ Aneurysm ______ Stroke ______ Transient Ischemic Attacks (TIA's) ______

Polio _____ Hepatitis _____ Respiratory Conditions ______ HIV _____ Tuberculosis _____ Fatigue ____

Asthma _____ Pneumonia _____ Diabetes _____ Allergies (list) ___________Fibromyalgia____________

Do you smoke? no yes

Do you exercise? no yes

Please list any accidents, falls, etc. :

____

____

List any medication you are currently taking: ____

____

Any previous hospitalization/surgery? ____

____

Recent X-Rays: Type & Date: ____

Women Only:

Pregnant: yes no

Menopausal: yes no

Due date: ____________________

Last Menstruation Date: ______________

I HAVE READ THE INFORMATION REGARDING OFFICE FEES, THE PAYMENT POLICY AND I CONSENT TO TREATMENT.

SIGNATURE: ____ DATE: __________________

Patient Name____ File No:__________