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/CELL: (____)_____ 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>.

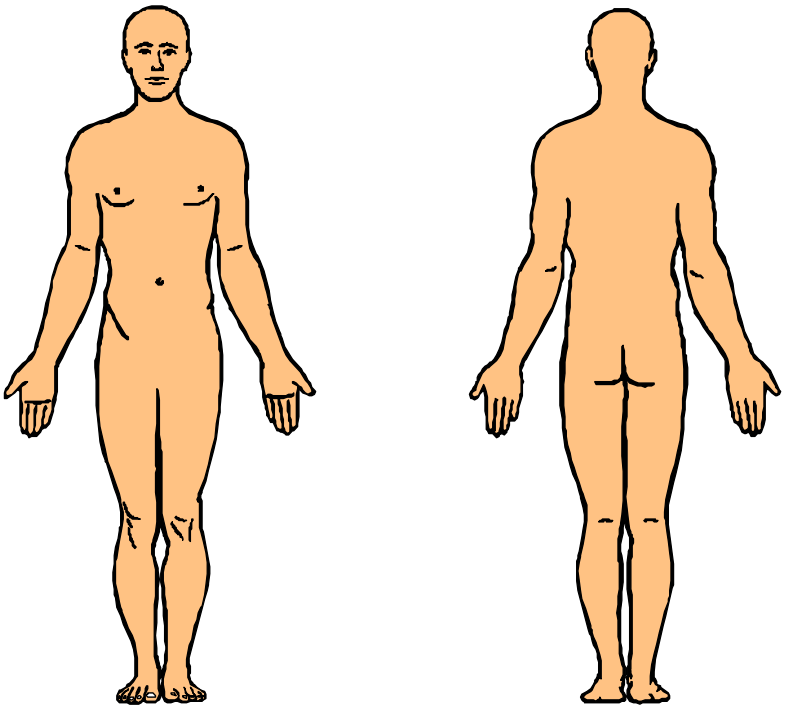
Numbness: • • • • •
• • • • •
• • • • •

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 AM AWARE OF OFFICE FEES, THE PAYMENT POLICY AND I CONSENT TO TREATMENT.

SIGNATURE: _____ DATE: _____

Patient Name: _____ File No: _____