Today's Date: _______________ Reason for visit: ☐ Chiropractic ☐ Athletic Therapy ☐ Massage ☐ Physiotherapy

PERSONAL INFORMATION

Name: ______________________________________ Name I prefer to go by: ___________________________

Male ___ Female ___ DOB: _____________ Age: _____ Occupation: _______________________

Email address: _______________________ Address: _________________________ City: __________________

Postal Code: ________________ Home Phone: _____________ Cell Phone: _____________

Marital Status: ________________ # of Children: ___________

How did you find us/who were you referred by? ____

Are you claiming under MPI or WCB? Y or N (circle) Claim # ____________ Date of Injury: ________________

What is the primary reason(s) you are seeking care today?

____

Have you been treated for this condition before and by whom (eg. Chiropractor, physio, etc)

____

PAST ACCIDENT/TRAUMA/INJURY HISTORY

Have you had any major injuries or traumas? When? ____

Have you ever had X-rays/MRI/CT scans taken of your area(s) of concern? (circle) If yes, where and when?

____

List any prior surgeries you have had and date: ____

LIFESTYLE

How much do you sleep every night? ______________________ Broken?_______________________________

How would you rate your stress level? 1(low) to 10(high): Current ___________ Your life in general__________

Are you active? If yes, how often? ____

How is your diet? Comments? ____

Medications? For how long?____

OTHER

How is the condition you are seeking help for from us affecting your life?

____

Is there any other area of your life you would like us to help you with?

____

Is there anything else you would like to add? ____