



NEW PATIENT INFORMATION FORM

Patient Data

Name (First) _____ (Last) _____ Gender M ___ F ___ Other ___

E-Mail-(optional) _____

**Your e-mail will NOT be shared with any 3rd parties and is used for occasional office announcements and promotions.*

Insurance Information

Do you have extended health benefits? Yes No

Name of insurance company _____

Policy # _____ Plan# _____ ID# _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

SIGNATURE _____

Mailing Address

Address _____ City _____ Province _____ Postal Code _____

Telephone(home) _____ (work) _____ (Cell) _____

Age _____ Birth Date (dd/mm/yr) _____ **Alberta Health Care #** _____

Occupation _____ Employer _____

Single ___ Married ___ Spouse's Name _____ Number of Children _____

Children's Names: _____

Medical Doctor _____ Date of Last Physical _____

Reason for consulting our practice: Chiropractic Laser Therapy Massage

Whom may we thank for referring you to our office? _____

Emergency Contact _____ Phone _____

Current Complaints

Reason for your visit/ chief complaint? _____

Nature of Injury/Condition: Automobile Work Injury Other

What day did it start? _____ How did it start? _____

Pains are: Sharp Dull Constant Intermittent Numbness/Tingling

What makes your pain/condition worse? _____

Is it worse at any time during the day? _____

What makes your pain/condition better? _____

How often do you feel it? Constant ___ times per day / week / month / year

Does the pain radiate (travel)? Yes No Where _____

Does the pain interfere with: Work Sleep Daily Routine Other

Have you had this problem before? Yes No Did it get Better? Yes No

Have you had X-Ray's of the area of concern? Yes No Where? _____

What previous treatment have you had for this pain/condition? _____

Did the previous treatment help? Yes No

Patient Name _____ Date _____ Chart # _____

Relevant Health History	Yes	No	Patient Comments
Any recent steroid injections?	<input type="radio"/>	<input type="radio"/>	
Exercise regularly?	<input type="radio"/>	<input type="radio"/>	
Females: Are you pregnant?	<input type="radio"/>	<input type="radio"/>	
Broken any bones? (please list)	<input type="radio"/>	<input type="radio"/>	
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	
Had sprains/strains?	<input type="radio"/>	<input type="radio"/>	
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	
Have you had Surgery? (please list)	<input type="radio"/>	<input type="radio"/>	
Do you wear orthotics?	<input type="radio"/>	<input type="radio"/>	
Do you take vitamin supplements? List:	<input type="radio"/>	<input type="radio"/>	

Circle all the conditions you have ever had, even if they don't seem related:			
Blood Clots	Headaches	Pins & needles in legs	Constipation
Hepatitis	Stiff Neck	Pins and needles in arms	Diarrhea
Circulation Problems	Neck pain	Buzzing/ringing in ears	Stomach upset
Heart Disease	Dizziness	Numbness in toes	Ulcers
Seizures	Fatigue	Numbness in fingers	Heartburn
Diabetes Type _____	Sleeping problems	Fainting	Problem's urinating
Arthritis/ Fibromyalgia	Cold Sweats	Light Bothers eyes	Cold hands/feet
Osteoporosis	Mood Swings	Loss of balance	Tension
Cancer	Depression	Loss of smell	Females: hot flashes
Herpes/ HIV	Irritability	Loss of taste	Menstrual pain
Back pain	Nervousness	Fever	Menstrual irregularity

Any other medical conditions:

Please list all medications:

Patient's Signature _____ Date _____