# NEW PATIENT INFORMATION FORM

## Patient Data

Name (First) _____ (Last)_____

Biological Sex M___ F___ Gender M ___ F ___ Other ____ Date: _____

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 #** _____

Please rate your pain by:

1) Circle **TWO numbers** that best describes your pain at its **BEST** and at its **WORST** this **past week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable pain

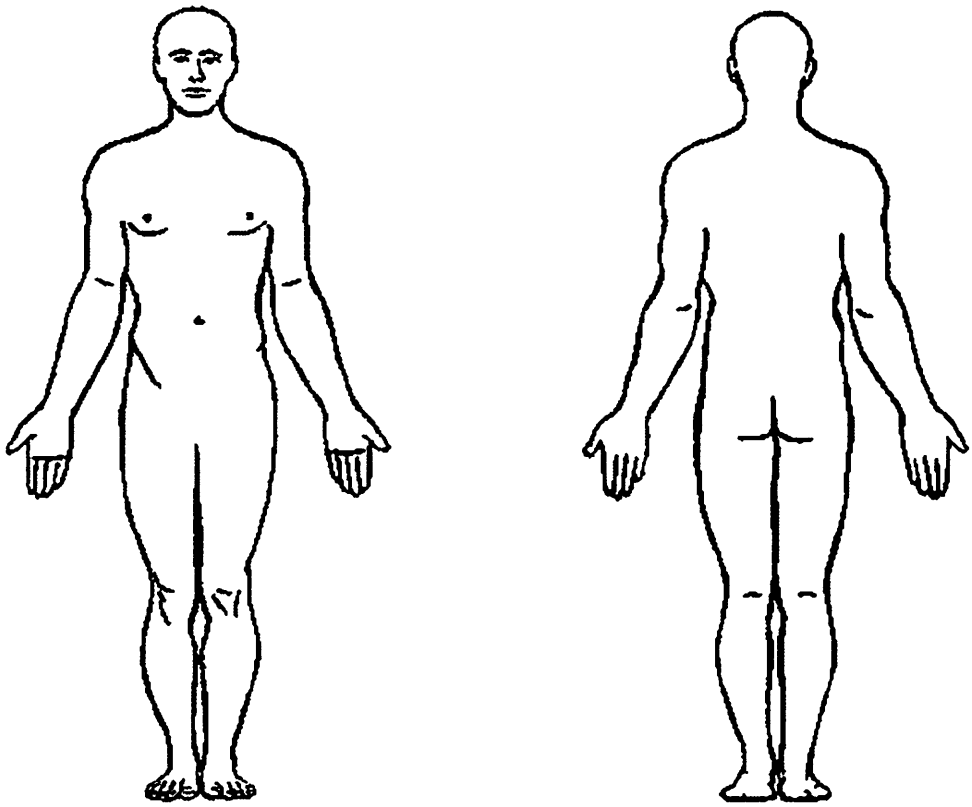
2) Circle the **ONE number** that best describes how pain has interfered with general activity this **past week.**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

**Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.**

**A**=Ache **P**=Pins & Needles **N**=Numbness
**B**=Burn **S**=Stabbing **O**=Other



| **Family History – Present and past health conditions Example: heart disease, cancer, diabetes, stoke, arthritis, ect.** |
| --- |
| |

**Patient Name** _____ **Date** _____ **Chart #** _____

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

| **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**_____