



New Patient Information Form

Please tell us about yourself (Please print)

Name: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: D ___ M ___ Y ___ Age: ___ Gender: M F

Marital Status: (please circle) Married Single Divorced Widowed

Social Insurance Number (If WSIB): _____

Health Card No: _____

Email: _____

Home Phone: _____ Leave Message: Yes No

Work Phone: _____ Leave Message: Yes No

Mobile Phone: _____ Leave Message: Yes No

What is your Occupation? _____

Duties: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ e.g. patient/sign/ad/etc.

Please tell us about the reason for your visit

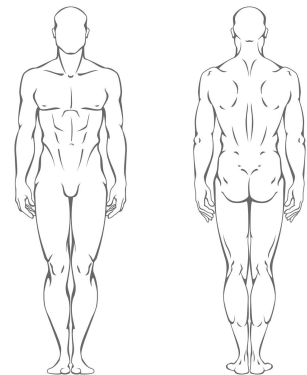
1. What is your main health complaint?

2. When did your symptoms first begin?

3. Do you feel your problem is: (please circle)

a) temporary b) permanent c) unsure

4. On the body diagram to the right, please indicate the problem area(s) using (P) pain, (N) numbness, and (W) weakness.



5. 10 being the worst pain you have ever experienced what would you rate your pain?

6. Do you have any additional/secondary areas of complaint? Please describe.

Please turnover and continue on the next page

7. What activities are you having problems with? (Please circle)

- | | | | |
|-------------|--------------|--------------|---------------|
| 1) Balance | 5) Housework | 9) Pushing | 13) Standing |
| 2) Bending | 6) Kneeling | 10) Reaching | 14) Stooping |
| 3) Fatigue | 7) Lifting | 11) Sitting | 15) Traveling |
| 4) Gripping | 8) Pulling | 12) Sleeping | 16) Walking |
- Other _____

8. Do you smoke? Yes/No For how long? _____ How many per day? _____

9. Which of the following provides some comfort? (Please circle)

- | | |
|----------------------|----------------|
| 1) Rest | 5) Ice |
| 2) Lying down | 6) Medication |
| 3) Changing position | 7) Stretching |
| 4) Heating pad | 8) Other _____ |

10. Which of the following have you experienced?

Please indicate as follows: (P) past (O) occasionally (F) frequently

- | | | | |
|----------------------|-----|--------------------------|-----|
| General muscle aches | [] | Eyes, ears, nose, throat | [] |
| Seizures | [] | Lung problems/asthma | [] |
| Fainting | [] | Bladder, kidney, bowel | [] |
| Neurological disease | [] | Hernia | [] |
| Mental disorders | [] | Digestive problems | [] |
| Memory problems | [] | HIV/AIDS, Hep C exposure | [] |
| Faulty posture | [] | Foot trouble | [] |
| Other _____ | [] | | |

Females only:

Menstrual Pain [] PMS []

Are you pregnant? Yes No

Do you take the Birth Control Pill? Yes No

11. Please check if YOU or anyone in your family now have or have had any of the following:

(If so, indicate relationship)

- | | | | | | |
|---------------|-----|-------|---------------------|-----|-------|
| Arthritis | [] | _____ | High blood pressure | [] | _____ |
| Cancer | [] | _____ | Obesity | [] | _____ |
| Diabetes | [] | _____ | Osteoporosis | [] | _____ |
| Heart Disease | [] | _____ | Stroke | [] | _____ |

12. Please list any allergies: _____

Please turnover and continue
on the next page

13. Please list any serious accidents, falls, fractures, hospitalizations and surgeries (type and year):

14. Please list any medications previous and present:

For Acupuncture Patients only (Please print)

Do you have any bleeding or clotting disorders? _____

Are you currently pregnant or trying to become pregnant? _____

Are you on blood thinners or medication with a similar result? _____

Long-term goals of acupuncture treatment (to be filled out by acupuncturist):

Previous health care (Please print)

Previous chiropractor's name: _____ Phone: _____

Date of last chiropractic visit: _____

Medical doctor's name: _____ Phone: _____

Billing information (Please print)

General

Do you have Extended Health Coverage: Yes No Unsure

Name of Extended Health Provider:

What services are covered?

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Foot Orthotics | _____ |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Naturopathy | |

Type of injury

Is this a Workplace Safety & Insurance Board injury? Yes No

Are your injuries related to a Motor Vehicle Accident? Yes No

Please turnover and continue on the next page

Our fee schedule

The account is the responsibility of the patient. Payment is expected in full when service is rendered.

- Initial Visit \$90.00
- Subsequent Visit \$55.00
- Acupuncture \$55.00
- Extended Visit \$55.00
- Concussion Visit \$60.00
- Active Release Technique \$55.00
- Physiotherapy Initial Visit \$90.00
- Physiotherapy Subsequent \$70.00
- X-rays Varies
- Costs associated with specific procedures or treatments will be discussed as required.

We understand that there will be circumstances for which you may not be able to keep your appointment, please call ahead to cancel and re-schedule the appointment. Missed appointments will be charged a \$15.00 fee.

Consent

- Fee Structure:** I have read the above, and agree and understand that I am responsible for all charges relating to my visit.
- Personal Information Release:** I consent to release personal information solely to Active Health Centre, and I understand that all such information will be held in strict confidence and only released with my written consent and/or as required by governing law.
- Exam Consent:** I consent to an examination in this office.
- Record Transfer Authorization:** I consent to the release of a medical report to my family doctor.
- Understanding:** I have had the opportunity to ask questions related to the content of this form.

Date: ____/____/____

Signature of patient, parent or guardian

Witness Signature

Printed name of patient, parent or guardian

Printed Name of Witness

(Parent/guardian must sign if patient is under 18 years of age)

Thank you