CONFIDENTIAL PATIENT INFORMATION

DATE:__________________

Full Name:____ Name you prefer:_____________
Address:__________________________________ City/Prov:_____________ Postal Code:_________
Phone: (home)________________________ (cell)_________________(work)_________________ext:___
How did you hear about our office?____________________________ Marital Status: S M W D Sep
DOB: (ddmmyyyy)_______________Age:______ email:___________________________________
Spouse's Name: _____________________# of children_____ Emergency Contact_________________
Your Occupation:_____________________________Employer:__________________________________
Address:____
Do you have additional Extended Health Care coverage?____ Insurance Company________________

MEDICAL HISTORY

WHY THIS FORM IS IMPORTANT – In this office our focus is on assisting people to function optimally in order for them to become more self aware, stronger, and healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time contributing to health problems.

Who is your medical doctor:____________________ When was your last physical examination?______
List any surgeries (include dates & reason): ____
____
List any hospitalizations (include dates & reason): ____
List any auto accident injuries (include dates): ____
List any on the job injuries (include dates): ____
List any major medical conditions you have ever had: (cancer, diabetes, heart disease, arthritis, etc):
____
List all current over the counter and prescription medication used (include reason used):_____________
____
List any health conditions that run in your family (cancer,heart disease,diabetes,arthritis,back problems, etc): ____
Have you been under chiropractic care? Who/reason:____
Do you smoke/use tobacco? No ___ yes ___
Exercise habits? Never ___ Occasional___ Frequent ___

Check any of the following symptoms you have noticed:

Headache	Low back pain	Sensitive to light or sound
Dizziness or light-headed	Leg/foot numbness/tingling	Visual or hearing disturbance
Jaw pain, clicking or locking	Leg/foot fatigue/weakness	Memory loss/problems
Pain or difficulty swallowing	Leg pain with walking	Irritability or depression
Neck pain or stiffness	Abdominal pain	Fatigue or loss of energy
Shoulder pain	Nausea or vomiting	Fainting or convulsions
Mid back pain	Diarrhea or constipation	Trouble with balance or coordination
Chest pain or cough	Blood in urine or stool	Sleep disturbances/problems
Pain/trouble breathing	Difficulty or pain w/urination	Rashes (face, body, limbs)
Arm/hand numbness/tingling	Abnormal menstrual periods.	Pain with exertion(activity,stairs,etc)

Do you have any allergies? Please list____

Do you wake rested?____________ How many hours of sleep per night? ____________________
Do you eat regularly?____________ How many meals per day? ___________________________

Have you had any of the following:

Now

Pain worse at night
Constant pain
Urinary discharge

Recent bladder infection (30 days)
Loss of bowel or bladder control
Osteoporosis/Osteopenia

Recent surgery (30 days)
Unexplained weight loss

Ever

History of cancer
History of stroke/pacemaker

History of IV drug use

History of blood transfusion

INFORMATION ABOUT YOUR CURRENT PHYSICAL ISSUES

What is your primary issue/problem? ______________________________

List other symptoms: ______________________________

When did your symptoms first begin (give date if possible)? ______________________________

How did your symptoms first begin? ______________________________

Is the pain constant or intermittent? Is your condition getting worse?_______

What activities aggravate your condition? (list) ______________________________

What activities lessen your symptoms? (list) ______________________________

List all the *doctors/therapists/specialists* seen for this problem and treatment given (alternative therapies as well):

1. ______________________________
2. ______________________________
3. ______________________________

Have you had: x-ray MRI or CT scan EMG Bone Scan Blood work

List all home remedies tried for this problem: ______________________________

Is your condition worse at certain times of the day or night? ______________________________

Does your condition interfere with: (yes/no) work?______ sleep?______ normal daily routine ______

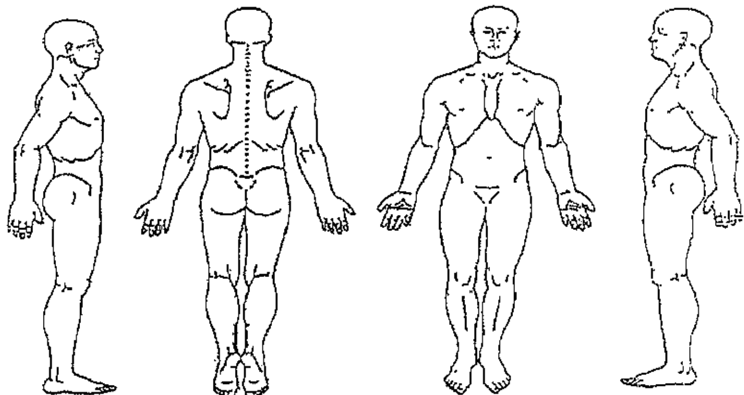
Have you had symptoms like this before? (yes/no) describe: ______________________________

Regarding Your Main Complaint : How bad is your pain? (0=no pain….10 = worst pain imaginable)

Right Now	1	2	3	4	5	6	7	8	9	10
Average	1	2	3	4	5	6	7	8	9	10
At worst	1	2	3	4	5	6	7	8	9	10

Draw the area of your symptoms using these symbols: (mark on the figures)

XXX = ache
*** = sharp/stab
ooo = numb tingling
⇨ = shooting
/ / / / = stiff/tight



Dr. Carolyn Dalgity
Chiropractor

FINANCIAL POLICY

Group or Individual Insurance
Health Insurance is an agreement between you and your insurance company, not between your insurance company and this office. As a courtesy to our patients, our office will complete any necessary reports and agree that services rendered are charged to you and your insurance company. Should your insurance carrier deny payment, you are personally responsible. Insurance companies typically take 3-4 weeks to send payment to our office. If after 60 days our office has not received payment from the insurance company, you will be billed directly for the outstanding balance.

Patients without Insurance
Payment is due at the time that services are received unless other payment arrangements have been made. Should the need arise; please contact us immediately to discuss a mutually agreeable payment plan.

"On The Job" Injury (WSIB)
We will gladly bill your care directly to your employer's insurance company, providing that we have received all forms related to your injury. Please understand that you must first report any work related injury to your employer and then follow the necessary steps to file a claim with your employers insurance. Should your employer's insurance carrier deny payment, you are personally responsible.

Personal Injury and Automobile Accidents
We will gladly bill your care directly to the responsible party. Please present all forms related to your accident, including claim numbers from the insurance company. If an attorney is handling your case, please notify us immediately.

Missed appointments
Not showing for your appointment is a problem for everyone. It delays your treatment, prevents another patient from coming in your place, and costs the office a great deal. Failing to contact this office 24 hours prior to your appointment time can result in a charge for that missed appointment This charge is solely your responsibility and not your insurance company's or your employers insurance company

Collection on Past Due Accounts
We make every effort to keep accounts from falling behind, and are willing to work with every individual in order to avoid the use of third-party collection specialists. If we must retain an attorney or collection company, the patient and/or guardian are responsible for all costs incurred with this process, including the attorney's fee, court costs, and filing fees. Accounts that are 90 days past due will be assessed a 3% per month service charge.

I, the undersigned, have read, understand and agree with the above policy.

_______________________________ _________________
Patient/Guardian Signature Date

_______________________________ _________________
Witness Signature Date