Patient Information Form

Name: _____
Last First

Address: _____
Street

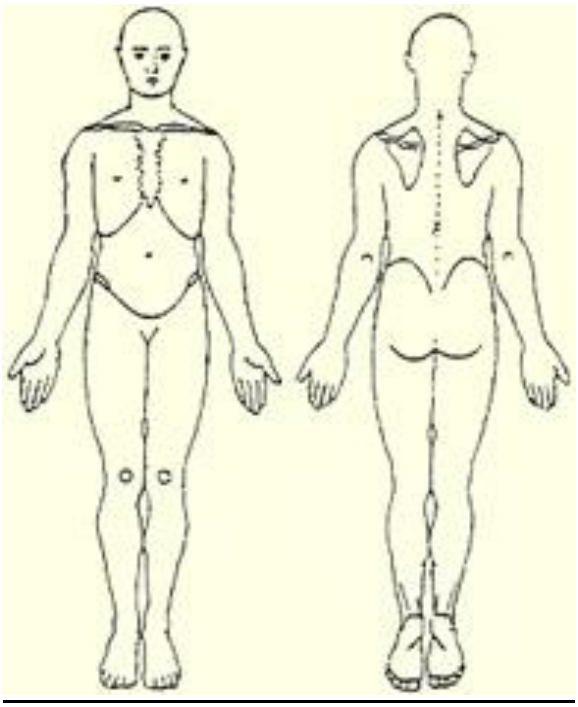
_____
City Province Postal Code

Contacts: _____
Home/Cell Work E-mail

Occupation: _____ Date of Birth: _____

Doctor: _____ Referred by: _____

MARK AREAS OF PAIN:



CONTINUED ON BACK

Medical Conditions (please check all that apply):

	Current	Previous		Current	Previous
Allergies _____	□	□	Migraine	□	□
Arteriosclerosis	□	□	Multiple Sclerosis	□	□
Arthritis: rheumatoid/osteo	□	□	Motor Vehicle Accident	□	□
Asthma	□	□	Phlebitis	□	□
Cancer: _____	□	□	Plantar Warts	□	□
Contact Lenses	□	□	Poor Circulation	□	□
Diabetes: Type I/Type II	□	□	Post-partum	□	□
Digestive Conditions	□	□	Pregnant: _____ weeks	□	□
Ear/Hearing Problems	□	□	Scoliosis	□	□
Emphysema	□	□	Skin Conditions	□	□
Endometriosis	□	□	Sleep Disorders	□	□
Epilepsy	□	□	Stroke	□	□
Headaches (not migraines)	□	□	Tinnitus (ringing in ears)	□	□
High/low blood pressure	□	□	Varicose Veins	□	□
HIV/AIDS/STI	□	□	Vertigo		
Joint Dislocations	□	□	Other: _____	□	□

Surgeries: _____

Do you have any pins, rods, plates or artificial joints? If so, where? _____

Treatments by other health care practitioners, If so, who? _____

Cancellation Policy and Agreement:

A time has been reserved exclusively for you. We require 24 hours notification to cancel an appointment. We reserve the right to charge you for the full appointment cost if you cancel with less than 24 hours' notice or fail to show up for your scheduled appointment. By signing below you agree to these terms.

Date: _____ Signature: _____

For Office Use Only

Thx: _____ Length: _____ ICBC: □