1STOP HEALTHCARE CLINIC

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NEW PATIENT FORM

Date of Visit (D/M/Y) ____/____/_____ Sex: M ☐ F ☐ Marital Status S ☐ M ☐ D ☐ W ☐

Name _____ **Date of Birth (D/M/Y)** ____/____/_____ Age _____
Last *Middle* *First*

Address _____ City _____ Postal Code _____

Phone (Home) _____ Phone (Cell) _____ Email _____

Occupation _____ Employer _____ Phone (Work) _____

Who referred you to the clinic? Family Physician ☐ Family/Friend ☐ Self ☐ Other ☐ _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: Name _____ Relationship to Patient _____

Phone (Home) _____ Phone (Cell) _____ (Work) _____

Family Physician: _____ Phone: _____

REASON FOR TODAY'S APPOINTMENT

Major Complaint(s)? 1) _____ 2) _____ 3) _____

How long have you had this complaint? _____

Since the onset of my symptoms (pain), my condition has? Improved ☐ Gotten Worse ☐ Stayed the Same ☐

Have you been treated recently for this condition? Yes ☐ No ☐ If yes, by whom? _____

Is your injury due to? Car Accident ☐ Work Injury ☐ Other ☐ _____

HEALTH INSURANCE INFORMATION

OHIP Card #: _____

Do you have extended health care benefits? Y ☐ N ☐ Do you have coverage for chiropractic care? Y ☐ N ☐

EHC/Insurance Company _____ Phone: _____

Policy Number: _____ Member ID Number: _____ Division Number _____

Policy Holder's Name: _____ Relationship to Patient? Self ☐ Spouse ☐ Mother ☐ Father ☐

WSIB Information

Claim Number: _____

Adjudicator: _____ Phone: _____

Auto Accident Information

Policy Number: _____

Insurance Co. _____ Phone: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to what? _____ type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due: _____
- ☐ gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____

_____

Current Medications: _____

condition it treats: _____

_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____

_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what? _____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

_____

_____

_____

Notes:

OFFICE USE ONLY
Date of initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

AUTHORIZATION OF CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and/or joints of the extremities as well as manual therapies to the associated soft tissue structures, as he or she deems appropriate I clearly understand and agree that I am responsible for all bills incurred at the time of treatment rendered. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable.

Also by signing, I grant the clinic to contact me via SMS and Email for appointment reminders.

_____ _____

Patient Signature Date