

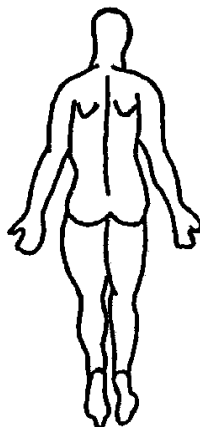
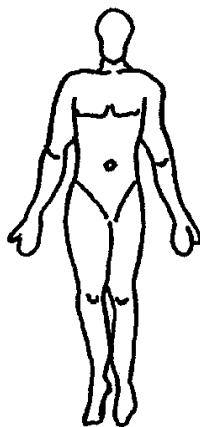
First Canadian Chiropractic and Acupuncture Centre

New Patient Admission Form

Name: _____ Date: _____
Date of birth (D/M/Y): ___/___/___ Address: (home) _____
City: _____ Province: _____ Postal code: _____
Telephone #: Home () ___-____ Office () ___-____ Fax () ___-____
Cell () ___-____ E-mail: _____
Occupation: _____ Marital Status & Children _____
Who referred you to First Cdn Chiro & Acup?
MD ___ Physio ___ Massage ___ Yellow Pages ___ Walk by ___ I'm a patient of the
medical clinic ___ An existing patient (name) _____
Website (which site?) _____ Other _____
Name of Medical Doctor: _____ Phone #: _____
Address: _____ Date of last visit _____

Please answer the following questions:

1. What are the main reasons you wish to see the Chiropractor? _____
2. How long have you had this problem? _____ Have you had it before? _____
3. What aggravates the problem? _____ Relieves it? _____
4. What do you expect from treatment? _____
5. Please use the following drawings to mark the areas where you have pain:



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1 First Canadian Place (King & Bay), Mezzanine Level
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6. Mark on this scale the level of your pain today (T), and in general (G)

(0 = no pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (10 = worst pain)

7. Mark the treatments that you have received so far for this problem:

Medication Chiropractic Acupuncture Physiotherapy Massage

Other treatments (please specify): _____

8. So far, which treatments have benefited you the most? _____

9. List all the medications and supplements you are taking, or have recently taken: _____

10. Do you have any scars? (please list) _____

11. Have you ever had any accidents/falls/trauma/injuries? _____

12. Please list quantity/day: Caffeine _____ Cigarettes _____ Alcohol _____

Please answer the following questions about your family medical history:

Have you or anyone in your family had: Heart Disease High Blood Pressure Diabetes
 Cancer HIV Other Diseases? Specify whom: _____

Please check the appropriate symptom if you have ever experienced it (J), are experiencing it now (JJ)

HEAD AND NECK

Neck Pain ____	Hearing Problems ____	ringing of the Ears ____
Headaches ____	Dizziness ____	Eye Problems ____
Nasal Problems ____	Jaw Problems ____	Sinusitis ____
Vision Problems ____	Sore Throat ____	Hoarse Voice ____

Other problems in these areas (specify): _____

CHEST, LUNG, HEART AND SKIN

Chest Pain ____	Palpitations ____	Blood Pressure Problems ____
Rapid Heart Beat ____	Chest Tightness ____	Excessive Dreaming ____
Insomnia ____	Night Sweats ____	Excessive/Little Sweating ____
Lung Problems ____	Asthma ____	Shortness of Breath ____
Allergies ____	Skin Problems ____	Restlessness, Irritability ____

Other problems in these areas (specify): _____

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DIGESTIVE SYSTEM AND MISCELLANEOUS

Bleeding Gums ____	Belching ____	Nausea, Vomiting ____
Heart Burn ____	Poor/Excess Appetite ____	Loss of Taste ____
Bloating ____	Abdominal Pain ____	Bowel Move't After Meal ____
Sleepy After Meal ____	Gas, Rumbling ____	Diarrhea ____
Constipation ____	Hemorrhoids ____	Gain'g/Los'g Weight Easily ____
Bruising Easily ____	Heavy Legs ____	Varicosities ____

Other Digestive problems (specify): _____

GYNECOLOGICAL SYSTEM

Painful Periods ____	Heavy Periods ____	Irregular Periods ____
Long Periods ____	Absent Periods ____	Pre-Menstrual Syndrome ____
Hot Flashes ____	Endometriosis ____	Painful Intercourse ____
Fertility Problems ____	Breast Problems ____	Miscarriages, Abortions ____

Other Gynecological problems (specify): _____

LIVER AND GALL BLADDER

Liver Problems ____	Sweaty Palms ____	Sweats Easily ____
Irritated Easily ____	Brittle Nails ____	Bitter Taste in Mouth ____
Muscle Cramps ____	Anxiety ____	Tension Headaches ____
Slow Digestion ____	Restlessness ____	Stiff Joints and Muscles ____

KIDNEY, URINARY TRACT, ENDOCRINE SYSTEM AND MISC

Kidney Stones ____	Kidney Problems ____	Urinary Bladder Problems ____
Prostatitis ____	Frequent Urination ____	Urinary Tract Infections ____
Incontinence ____	Low Sexual Drive ____	Erectile Dysfunction ____
Feeling Cold ____	Feeling Hot ____	Low Energy ____
Cold Hands ____	Cold Feet ____	Joint Pain ____
Weak or Sore Knees ____	Low Back Pain ____	Bone Problems ____

Please list any muscle/joint problems or ANY other problems anywhere else: _____

DO NOT WRITE BELOW THIS LINE

Patient Accepted: ____ Yes ____ No ____ Referred Out

Doctor's Signature

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OFFICE POLICIES

To increase the efficiency of our office and to ensure that you will receive maximum benefit from the care offered, we ask you to follow these policies:

1. It is our policy to accept payment on completion of each treatment. We accept cash, cheque, Visa, MasterCard and debit.
2. You may find that your extended health care covers you for Chiropractic or Acupuncture. Please check with your carrier. We will provide the necessary receipt to submit to your insurance company when necessary.
3. Any missed appointment or cancellation on the scheduled day is subject to a \$20 service charge.
4. A service charge of \$20 will be charged for NSF cheques.

I clearly understand and agree that all services rendered are charged directly to me, that fees are due when services are rendered and that I am personally responsible for the payment. I understand and agree that certain health care and accident insurance policies cover Chiropractic and Acupuncture and I agree that these policies are an arrangement between an insurance carrier and myself.

Patient's Signature: _____ Date: _____

Guardian's Signature

Authorizing Care: _____ Date: _____