



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

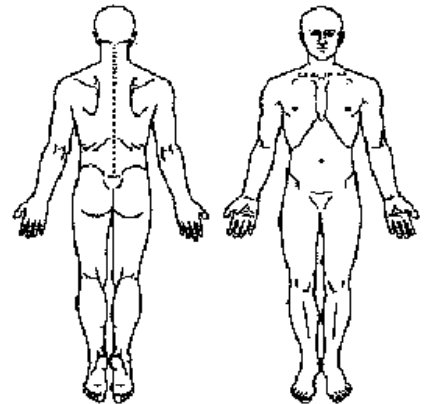
1. What is your main health complaint?

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. On a scale of 0 to 10, where 10 is normal, how much have you recovered since the onset of the problem?

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

Please turnover and continue
on the next page →

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

13. Please list any surgeries (type and year):

14. Please list any medications previous and present:

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 case? 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** \$70.00
- **Subsequent visit** \$35.00
- **Extended visit** \$50.00
- **Graston Technique** \$50.00
- **Active Release Technique** \$50.00
- **X-rays** Vary with procedure
- **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