

New Patient Application
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Welcome to Barrhaven Family Chiropractic and Wellness Centre!
Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

How would you like to be addressed: _____

Address: _____ E-mail: _____

City: _____ Province: _____ Postal Code: _____

Phone: Home: _____ Work: _____ Fax: _____

Cell#: _____ Pager: _____ Marital Status: M/W/D/S

Birth date: ____ / ____ / ____ Age: _____
(DD/MM/ YEAR)

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____ Mark area of Health Concerns

Chiropractic techniques you've had good success with: _____

Last time you went to previous Doctors of Chiropractic: _____

General Practitioner: _____ City: _____

Your Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer: _____

Children's Names and Ages

Favorite Hobbies or interests: _____

What's most important to you with the relationship with our office?

(Over)

Stress to your spine and nervous system can also cause a wide variety of other health concerns. In the past 6 months, have you experienced any of the following? (Please Circle)

Headaches	Nervousness	Fatigue	Sinus Problems
Fainting	Shortness of Breath	Dizziness	Severe Menstrual Pain
Neck Pain	Stomach Upset	Light Bothers Eyes	Ears ring/buzzing
Loss of Smell/ Taste	Tension	Asthma	Feet/ Hands Cold
Sleeping problems	Diarrhea	Back Pain	Depression
Neck Stiffness	Allergies	Recurring Sore Throats	Fever
Ear Aches	High Blood Pressure	Loss of Balance	Constipation
Numbness & Tingling (Hands, arms, feet, legs)			

Health Reasons For Consulting Our Office:

1. _____ 2. _____ 3. _____ 4. _____

On a scale of 1-10, how committed are you to getting rid of this problem. _____

Have you had same or similar problem(s) before? _____ Yes _____ No

Explain: _____ How long: _____

Father/ Mother/ Brother/ Sister/ Children, with similar problems? _____

Other Doctors who have treated this problem: _____

Surgery you have had: _____ Medications _____

Is there any chance that you could be pregnant? Yes _____ No _____

Do you know what a subluxation is? If yes, please describe _____

Have you ever diagnosed with cancer? _____ If so, what kind? _____

Do you have extended health insurance? _____ Company Name & Policy # _____

Method of Payment for first Visit:

____ Cash ____ M/C ____ Visa ____ Amex ____ Interac ____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences which are usually of a temporary nature. The chances of this happening are less than one in 5.85 million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of care for neck conditions. If you have any questions about this please ask your chiropractor.

I have read the above statement and consent to treatment, if the doctor accepts my case.

Signature _____ Date signed _____

