Patient Information

Date:

Name: _____ AHC#: _____

Address: _____ City: _____ Prov.: _____

Postal Code: _____ Email Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Birthdate: (dd/mm/yy): _____

Gender: ○ Male ○ Female

Weight: _____ Height: _____

Do you have Additional Insurance? ○ Yes ○ No (Please present card)

Is this appointment related to a Motor Vehicle Accident (MVA): ○ Yes ○ No

Is this appointment related to a Workers Compensation Injury (WCB): ○ Yes ○ No

Do we have consent to email you newsletters or other office notifications? ○ Yes ○ No

Marital Status: ○ Married ○ Common Law ○ Single ○ Separated ○ Divorced ○ Widowed

Children: _____ Ages_____

Occupation:_____ Employer: _____

Medical Doctor: _____ Last seen: _____

Previous Chiropractor: _____ Last seen: _____

Other Health Care Providers (List): _____

Emergency Contact Name: _____ Phone number: _____

Are you taking any medication: ○ Yes ○ No List: _____

Surgery (type and date): _____

Previous Automobile accidents (date): _____

Broken bones (date): _____

How did you hear about our office? ○ Friend/family ○ Website ○ Drive by
○ Medical Doctor or other Health Care Provider ○ Other