

145 King Street West, Suite 1710
Toronto, Ontario M5H 1J8
[tel] 416.366.1710
[fax] 416.366.1712
[web] www.theclinic-toronto.com

patient[information]

Last Name: _____ First Name: _____

Sex: M F Age: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

Email Address: _____ Occupation: _____

Emergency Contact Person: _____ Phone: _____

Medical Doctor: _____ Phone: _____

complaint[history]

What is your main complaint? _____

When did you first notice this complaint? _____

What caused this complaint? _____

Describe your current pain/discomfort: _____

How often does your pain occur? _____

Is your condition getting worse? Y N

Rate your pain/discomfort: (none) (worst pain ever)
0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your complaint? _____

What activities relieve your complaint? _____

Does your pain radiate or shoot anywhere else? If so, where?

Have you received any treatment for this complaint? If so, what kind of treatment?

Have you ever been treated for the same/similar complaint in the past? If so, when?

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health[survey]

Do you have any ongoing medical problems or disabilities?

Please list dates and descriptions of any previous accidents or surgeries you have had.

Please list any medications you are currently taking and what you are taking them for.

Do you drink alcohol? Y N If yes, how many drinks per week? _____

Are you a smoker? Y N If yes, how many packs per day? _____

family[history]

Marital Status: Single Married Divorced Widowed Children: _____

Please check if any of your family members has or ever had any of the following conditions, and if so, how are they related to you?

Cancer _____

Arthritis _____

Heart Disease _____

High Cholesterol _____

Stroke _____

Hypertension _____

Diabetes _____

Other _____

patient[signature]

The information I have provided on this form is true and accurate. I will inform the[clinic] of any changes to my status. I also agree and understand that I have been made fully aware of and am fully responsible for the payment of all charges relating to my visit to the[clinic].

Fee Schedule:

[Initial] Chiropractic Consultation	\$150
[Comprehensive] Chiropractic Visit	\$100
[Express] Chiropractic Visit	\$50
Aqua Massage Session	\$20
Custom Orthotics	\$500-\$600

Signature: _____

Date: _____