New Patient Form

Patient Contact Information:

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Name: ______________________ Occupation: ______________________

Date of birth: ______________(m/d/y) Age: ________

Address: ______________________ City:__________ Province: _____Postal code:__________

Phone: Home ______________________ Cell: ______________ Work:______________

Email address: ____

Emergency contact: ______________ Relationship:__________ Phone:______________

How did you hear about this office? ____

Prior Medical / Chiropractic Care:

Have you ever been treated by a chiropractor? □ yes □ no

Previous chiropractor's name: ______________________ Phone:______________

Date of last chiropractic visit:____

Family doctor's name: ______________________ Phone: ______________

Date of last physical:____

Billing Information:

Type of injury

Is this a *Workplace Safety & Insurance Board* injury? □ yes □ no (if no, do NOT fill in the following)

What is your social insurance number? ____

WSIB claim number? ______________________ Date of accident: ______________(m/d/y)

Employer's name: ______________________ Phone: ______________________

Employer's address:____

All accounts are the responsibility of the patient. Fees are due as services are rendered. Your supplemental or extended health care insurance may provide coverage for chiropractic services. A receipt will be issued for each payment for this purpose.

I agree and understand that I am responsible for all charges relating to my visit.

⇨ Patient/Guardian Signature: ______________________ Date: ______________________ (m/d/y)

Privacy Code:

Privacy of personal information is important. Collection, use and disclosure of this information will be in a responsible way. How personal information is handled will be open and transparent.

Personal information is information about an identifiable individual. As part of your patient file, the following will be retained: your health history, health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. Records will also be maintained for billing purposes. Only necessary information is collected about you. Information about you will only be shared with your consent. The use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Outlined here is how the clinic uses and discloses this information: to deliver safe and effective patient care, to enable us to contact you, to communicate with other health care providers, to complete and submit claims on your behalf to third party payors, to comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act, to process payments and collect unpaid accounts.

I have reviewed the above information that explains how my personal information will be used. I agree that Dr. Miron, can collect, use and disclose my personal information as set out above.

⇨ Patient/Guardian Signature: ______________________ Date: ______________________ (m/d/y)

Health History & Symptom Diagram

Patient Name: ______________________________ File #: _________________ Date: __________________

Presenting Complaint

Current complaint(s):____
Other doctors seen for this condition? □ yes □ no If yes, who:____
Type of treatment: _____________________________ Results:____
When did this condition begin? __________________ Has this condition occurred before? □ yes □ no
Is this condition (check all that apply): □ job-related □ auto-related □ home injury □ sport injury □ fall □ other:
What aggravates your condition?

□ sitting □ standing □ bending □ lifting □ walking □ lying down
□ cold □ dampness □ other:

What relieves your condition?

□ bed rest □ ice □ heat □ massage □ medication
□ other:

Is it getting: □ worse □ better □ constant □ comes and goes
Character of pain:

□ sharp □ dull □ ache □ numb □ burning □ pins and needles

Please rate the intensity of your pain out of 10 (if 10/10 is the worst pain you have ever had):

at its worst: ___/10 currently: ___/10

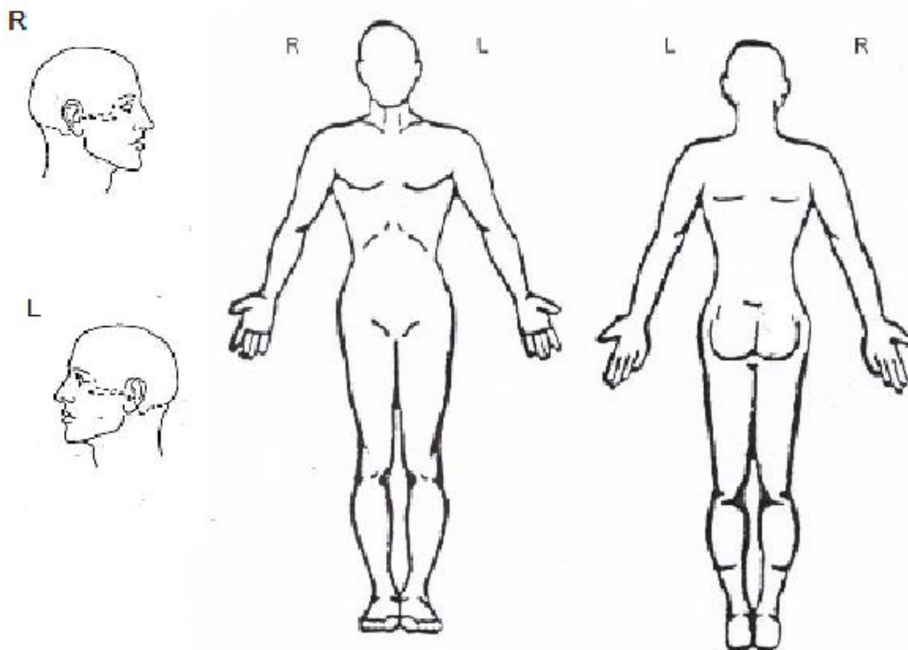
How does this problem interfere with:

Your ability to work? ____
Your ability to enjoy sports/hobbies/family time? ____

Past Health History

Major accidents or falls:____
Surgeries & hospitalizations: ____

Symptom Diagram



In the diagrams provided, please mark the areas on your body, which you feel best, represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided.

Symbols:
Numbness: ========
Pins & Needles: °°°°°°°°°

Burning: xxxxxxxx
Stabbing & Sharp: ~~~~~~~~

Dull & Aching: ΔΔΔΔΔΔ
Stiff & Tight: 22222222

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

⇨ Patient/Guardian Signature: ___________________________ Date: _______________________ (m/d/y)

Health Status Survey

Patient Name: ______________________________ File #: _________________ Date:____________________

Please **X** the box for any conditions or symptoms **presently** causing you problems.
Please check (√) the box for those conditions or symptoms **that you have had in the past.**

General Symptoms
- □ Loss of Consciousness
- □ Blackouts
- □ Headache
- □ Fever
- □ excess sweating
- □ Night sweats
- □ Loss of weight
- □ Night pain
- □ Generalized pain
- □ Nervousness
- □ Convulsions
- □ Loss of sleep

Neurologic
- □ Dizziness
- □ Fainting
- □ Problem speaking
- □ Problem swallowing
- □ Blurred vision
- □ Double vision
- □ Nausea
- □ Clumsiness
- □ Numbness or tingling

Muscles and Joints
- □ Neck pain
- □ Mid back pain
- □ Low back pain
- □ Tailbone pain
- □ Shoulder pain
- □ Arm / forearm pain
- □ Elbow pain
- □ Wrist / hand pain
- □ Hip pain
- □ Knee pain
- □ Ankle / foot pain
- □ Arthritis
- □ Loss of strength

Eyes/Ears/Nose/Throat
- □ Failing vision
- □ Eye pain
- □ Failing hearing
- □ Earache
- □ Ring/buzz in ears
- □ Sinus infection
- □ Enlarged thyroid
- □ Enlarged glands

Respiratory
- □ Asthma
- □ Chronic cough
- □ Spitting up phlegm
- □ Spitting up blood
- □ Difficulty breathing

Cardiovascular
- □ Bleeding disorder
- □ High blood pressure
- □ Chest pain
- □ Stroke
- □ Hardening of arteries
- □ Varicose veins
- □ Swelling or ankles
- □ Poor circulation
- □ Heart / blood disease
- □ Angina

Genitourinary
- □ Trouble urinating
- □ Blood in urine
- □ Kidney infection
- □ Bed wetting
- □ Prostate trouble

GU for Women
- □ Painful menstruation
- □ Excessive flow
- □ Hot flashes
- □ Irregular/absent cycle
- □ Cramping/backache
- □ Vaginal discharge
- □ Swollen breasts
- □ Lump in breasts

Currently on birth control pills/patch? □ yes □ no

Previously on birth control pills/patch? □ yes □ no

# of pregnancies: ____
# of children: _______

Skin
- □ Rashes/itching
- □ Bruise easy
- □ Dryness
- □ Boils
- □ Hives (allergies)

Gastrointestinal
- □ Poor appetite
- □ Indigestion
- □ Excess hunger
- □ Belching or gas
- □ Vomiting
- □ Pain over stomach
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids (piles)
- □ Jaundice
- □ Gall bladder trouble
- □ Intestinal worms
- □ Ulcer
- □ Diabetes

Have you ever had any fractures?
□ yes □ no
If yes, where? __________________

Have you ever been in a car accident?
□ yes □ no
If yes, when?___________________

Have you ever been hospitalized?
□ yes □ no
Why? When?__________________

Are you currently a smoker?
□ yes □ no
How much?
Did you smoke previously?
□ yes □ no
How much? ___________________

Have you ever been diagnosed with:
Cancer? □ yes □ no
HIV/AIDS? □ yes □ no
Hep A/B/C? □ yes □ no

Medications (list):