Patient Name: Date:

Horseshoe Wellness
CHIROPRACTIC & ACUPUNCTURE

(Please Print)

Today's date:			OHIP#		
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Spouses Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Number of Children: Ages:			Cell Phone # ( )	Home phone # ( )	
Street address:	City:		Province:	Postal Code:	
Occupation:	Employer:		Employer phone no.: ( )		
Who may we thank for referring you to this office (please check one box):			❑ Friend	❑ Internet	❑ Family
	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Email Address:					

MEDICAL DOCTOR INFORMATION			
Family Doctor:	#	Does your M.D. Know about this condition? Yes □ No□	Results of Treatment:
Address:		Date of last appointment:	Last Physical:

CURRENT HEALTH HISTORY INFORMATION					
Current Complaints:					
When did this condition begin?		Has this condition occurred before? No□ Yes□ When:			
Is this condition:	Job related (WSIB) □	Auto-Related (MVA) □	Home Injury □	Fall □	Other:
Date of Accident:	Time Of Accident:			Was there a report/ claim? Yes □ No □	
What aggravates your condition?	Sitting □ Standing □ Bending □ Lifting □ Walking □ Lying down □ Cold □ Heat □ Dampness □ Raising arms □ Other □ .				
What Relieves your condition?	Bed Rest □ Ice □ Heat □ Massage □ Medication: _____ Other: .				
Is it getting:	□ Worse □ Constant □ Comes/ Goes □ Better		Character of Pain: □ sharp □ dull □ ache □ numb □ pulsing/throbbing □ pins and needles □ burning		
Severity of your pain (place an x indicating grade of severity)	Least 1 2 3 4 5 6 7 8 9 10 Worst				
Current	□ Heart □ Diabetes □ Pain □Blood pressure □Thyroid □Birth Control □ Arthritis				

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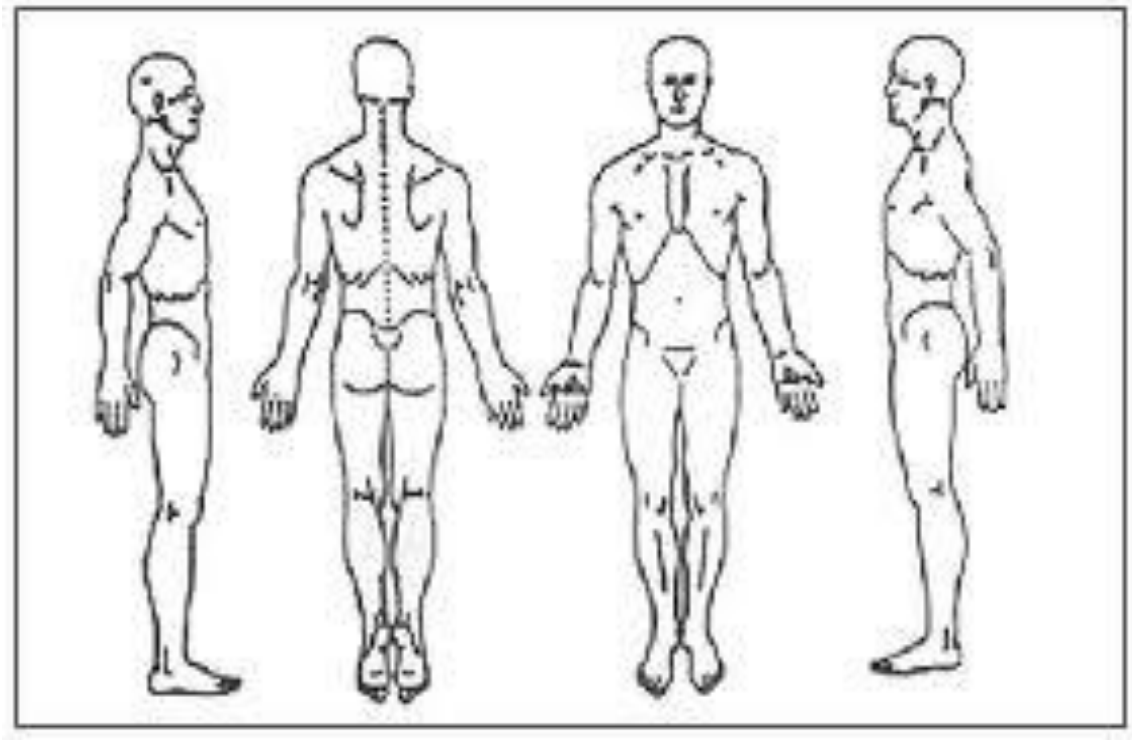
Medications:	□Cholesterol □ Other
Please list all known current **medications**;	
Previous Imaging:	□ X-Ray □ CT Scan □ MRI □ Ultrasound Results:

Please mark on the diagram to the right where the following pain is by writing the letter on the location of the type of pain.



Ache – A
Burning –B
Stabbing- S
Pins and Needles - P

IN CASE OF EMERGENCY			
Name of local friend or relative :	Relationship to patient:	Home phone # ( )	Work phone # ( )

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PAST HEALTH HISTORY

Cancer Location:_____ Date: _____	**Present or Past Symptoms**	C-Current F- Frequent O-Occasional	
C FO Cardiovascular	**C F O Neurological**	**C F O Muscle and Joint**	□ □ □ Hay fever
□ □ □ Stroke Date: _____	□ □ □ Allergies: _____	□ □ □ Arthritis	□ □ □ Hoarsness
□ □ □ Heart attack	□ □ □ Chills	□ □ □ Bursitis	□ □ □ Nasal obstruction
□ □ □ Chest pain	□ □ □ Convulsions	□ □ □ Foot Trouble	□ □ □ Nosebleeds
□ □ □ Rapid Heart Beat	□ □ □ Dizziness / Vertigo	□ □ □ Hernia	**C F O Gastrointestinal**
□ □ □ Slow Heart Beat	□ □ □ Fainting	□ □ □ Osteoporsis	□ □ □ Excessive hunger
□ □ □ Swelling of Ankles	□ □ □ Fevers	□ □ □ Neck pain	□ □ □ Gas
□ □ □ Hardening Artery	□ □ □ Headaches	□ □ □ Shoulder pain	□ □ □ Liver Trouble
□ □ □ High blood pressure	□ □ □ Loss of Sleep	□ □ □ Mid back pain	□ □ □ Colitis
□ □ □ Low Blood Pressure	□ □ □ Nervousness/ Stress / Anxiety	□ □ □ Low back	□ □ □ Irritable Bowel
□ □ □ Poor Circulation	□ □ □ Depression	□ □ □ Arm pain	□ □ □ Constipation
□ □ □ Fainting	□ □ □ Neuralgia	□ □ □ Leg Pain	□ □ □ Diarrhea
	□ □ □ Numbness	□ □ □ Knees	□ □ □ Difficult digestion
Family History – please name relation	□ □ □ Sweats	□ □ □ Difficulty chewing/ clicking jaw	□ □ □ Abdominal Distention
Diabetes: Type 1 □ Type 2□ Date Diagnosed:_____	□ □ □ Loss of weight unexplained	□ □ □ family history of foot problems	□ □ □ Stomach pain
High Blood pressure:	□ □ □ Tremors	□ □ □ shin splints	□ □ □ Acid Reflux
Heart Disease:	□ □ □ Obsessive Defiance disorder	□ □ □ bunions/ callus/ corns	□ □ □ Gall bladder trouble
Cancer Location:_____	□ □ □ Attention deficit disorder	□ □ □ increased pain with standing	□ □ □ Hemorrhoids
Stroke Date : _____	□ □ □ Autism	□ □ □ Walking Problems	□ □ □ Jaundice
	□ □ □ Down's Syndrome	**C F O Eyes/ Nose & Throat**	□ □ □ Poor Appetitie
Thyroid Hypo □ Hyper □	□ □ □ Developemental Disabilities	□ □ □ Colds	□ □ □ Nauseau
	□ □ □ Learning disabilities	□ □ □ Crossed Eyes	□ □ □ Vomiting
Childhood Illnesses / Diseases	□ □ □ Weakness sudden loss of strength	□ □ □ Deafness	Do you Smoke? Y /N
□ Polio	□ □ □ Paralysis	□ □ □ Dental decay	How much?
□ Chicken pox	□ □ □ Loss of Consciousness	□ □ □ Asthma	Do you exercise? Y / N
□ Rubella	**C F O Genito-Urinary**	□ □ □ Ear Infections	How Much?
□ Measles	□ □ □ Bed Wetting	□ □ □ Ear Discharge	**C FO Women Only**
□ Mumps	□ □ □ Blood in Urine	□ □ □ Ear noises	□ □ □ Cramps
□ Influenza	□ □ □ Frequent urination	□ □ □ Sinus Infections	□ □ □ Heavy Flow
□ Tuberculosis	□ □ □ Loss of urine control	□ □ □ Englarged glands	□ □ □ Light Flow
□ Epilepsy Date:	□ □ □ Kidney Infection	□ □ □ Enlarged thyroid	□ □ □ Irregular cycle
□Whooping Cough	□ □ □ Painful Urination	□ □ □ Sore throat	□ □ □ Painful Cycle
□ Pneumonia	□ □ □ Prostate trouble	□ □ □ Tonsillitis	□ □ □ Discharge
Diabetes: Type 1 □ Type 2□ Date Diagnosed:_____	□ □ □ Smell of Urine	□ □ □ Eye pain	□ □ □ Sore Breasts
	□ □ □ Bowel control	□ □ □ Failing vision	Menopausal: Y / N
□ Rheumatic Fever	□ HIV	□ □ □ Far sighted	Last Menstruation Date:

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Thyroid Hypo □ Hyper □	□ Sexual transmitted infection	□ □ □ Gum trouble	Pregnant: Y /N

OFFICE POLICIES

Appointment Scheduling/ missed appointments: Please allow 24 hours notice to change appointments. We understand that emergencies do come up but not notifying the office does not allow for other patients to be scheduled. Not allowing this time will result in a $10.00 rescheduling fee.

Initial _____

Broken Appointments: "No Show" appointments are subject to a $15.00 fee. Please give 24 hours notice so that reception can fill your space to service others in need. If appointments are repeatedly missed, we will, regretfull , have to dismiss you from care. We can make reminder call at your request if needed.

Initial _____

Financial Agreements: All service are pay per service we do not have an accounts outstanding. Each patient is responsible for paying for their treatment the day of treatment. I understand that I am financially responsible for any balance.

Initial _____

Chiropractic Excellence: Healing takes time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with your chiropractor. We want you to get the most from your health care.

Initial _____

Referrals: We believe that health comes from within and that a healthy nervous system is essential for a long healthy life. The health of your loved ones is also important to us too. If there is someone that you know that you would like to refer to us, please let us know and we will provide you with a New Patient Intake Form. If you would like, you may invite them to come observe one of your treatments.

Initial _____

We respect your privacy: We respect your privacy and will only collect information from you that is essential for your care in our office. Please consent for us to reach you in the following manner;

Would you like reminder calls? We do reminder calls two days before your appointment. If you have made an apt within two days you will not receive a reminder call.

Initial _____

To contact you via email *Initial* _____

To Contact you by phone and leave messages *Initial* _____

To thank you for referrals *Initial* _____

To receive newsletters via email *Initial* _____

To send your report of findings to your medical doctor. *Initial* _____

I also authorize Horseshoe Ridge Chiropractic & Acupuncture or insurance company to release any information required to process my claims regarding MVA, WSIB or private health insurance company.

Patient Signature _____

Date: _____

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