



Cabana Chiropractic
&
HEALTH CENTRE

Chiropractic · Massage · Naturopathy · Osteopathy · Acupuncture

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PERSONAL AND CONTACT INFORMATION

NAME: _____

Sex: M F Age: _____ Birthday: _____

FOR OFFICE USE ONLY

Date: _____ Pt. No. _____

Address: _____

Street Number and Name

City

Province

Postal Code

Which number is best to reach you? Cell: () _____

Home: () _____

Work: () _____ Ext. _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Name of Medical Doctor: _____ Date of last MD visit: _____

Whom may we thank you for referring you today? _____

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MOTOR VEHICLE OR WORKPLACE ACCIDENT INFORMATION

Is your condition the result of a motor vehicle or workplace accident? Yes No

→ If no, please move on to section 3.

Type: Motor Vehicle Workplace

Date of Accident: _____

Has this accident been reported and if so, to who? Family Doctor

ER Physician

Supervisor/Employer

Auto Insurance Rep/Adjuster

What area of the body was injured in your accident? _____

Workplace Accident Claim Number: _____

Motor Vehicle Accident Information:

Auto Insurance Company: _____

Adjuster: _____

Adjuster Phone Number: () _____ Ext: _____

Adjuster Fax Number: () _____

Claim Number: _____ Policy Number: _____

Reason for Visit:

How did this happen?

Mark an X on the picture where you continue to experience the reason(s) for your visit:

When did your symptoms appear? _____

Is this condition getting worse? Yes No

Rate the severity of your pain on scale ranging from
1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling

How often do you have this pain? _____

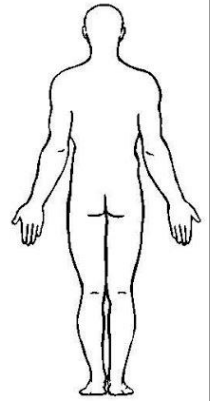
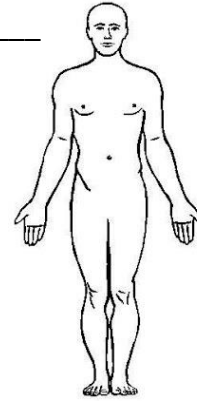
Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Movements painful to perform: Sitting Standing Walking Bending Lying down

Examinations performed on condition:

<input type="checkbox"/> MRI	Area of Body: _____	Location of test: _____	Date: _____
<input type="checkbox"/> CT	Area of Body: _____	Location of test: _____	Date: _____
<input type="checkbox"/> X-ray	Area of Body: _____	Location of test: _____	Date: _____
<input type="checkbox"/> Ultrasound	Area of Body: _____	Location of test: _____	Date: _____



What other types of treatment have you had? _____

Notes:

Please check off conditions you are experiencing or have experienced in the past:

Cardiovascular

- High blood pressure
- Low blood pressure
- High Cholesterol
- Myocardial infarction
- Heart Disease
- CCHF
- Phlebitis
- Stoke
- Pacemaker
- Poor circulation
- Varicose Veins

Respiratory

- Chronic Cough
- Asthma
- Emphysema
- Bronchitis

For Women

- Pregnant
- Due: _____
- IUD
- Menopause

Digestion

- Ulcers
- Liver/ Gallbladder
- Indigestion/ Heartburn
- Kidney/ Bladder
- Nausea
- Constipation/ Diarrhea
- Other _____

Muscles/ Joints

- Limited movement
- Arthritis; O.A. R.A.
- Fractures;
location: _____
- Strain/ Sprain
- Swelling
- Pins, plates, rods;
location: _____
- Foot trouble

Allergies:

Head and Neck

- Whiplash
- date: _____
- Dizziness/ Fainting
- Headaches/ Migraines

Infections

- Hepatitis
- Tuberculosis
- HIV
- Diabetes Type ____
- Other: _____

Medication/ Surgery

Recent Surgery:

- 1) _____
- Date: _____
- 2) _____
- Date: _____

Medications:

Any other health concerns/ conditions:

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INSURANCE INFORMATION

Primary Health Insurance:

Active Health Insurance: Yes No

Insurance Company: _____

Plan Member Name: _____ Relationship to you: _____

Contract/ Plan #: _____ ID#: _____

Maximum amount allowed per year: \$ _____ Amount Remaining: \$ _____

Are benefits per calendar year or based on the first paid claim? Cal. Year 1st claim

If benefits begin on the date of the first claim, what is the date? _____

Deductible: Yes No Amount: \$ _____

Has your deductible been satisfied this year? Yes No

If no, how much of your deductible is still remaining? \$ _____

Secondary Health Insurance

Active Secondary Health Insurance: Yes No

Insurance Company: _____

Plan Member Name: _____ Relationship to you: _____

Birthdate of Plan Member: _____

Contract/ Plan #: _____ ID#: _____

Maximum amount allowed per year: \$ _____ Amount Remaining: \$ _____

Are benefits per calendar year or based on the first paid claim? Cal. Year 1st claim

If benefits begin on the date of the first claim, what is the date? _____

Deductible: Yes No Amount: \$ _____

Has your deductible been satisfied this year? Yes No

If no, how much of your deductible is still remaining? \$ _____

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CUSTOM-MADE PRODUCTS AND OTHER ITEMS

Here at Cabana Chiropractic & Health Centre, we offer many different types of services and products to contribute to your health. Some of the products that could benefit you include custom foot orthotics, portable TENS units and braces. Please note that for any of the products listed above, a deposit may apply.

In the following circumstances, I understand I am responsible to pay at the time of service or at the time of product purchase:

- If I do not have any insurance that will cover the product or service
- If my insurance carrier sends payment directly to me or requires that I pay and submit my expense
- When my coverage does not pay 100% or has been used up (I am responsible for the copayment)
- When a product is custom made (deposit may be required before ordering)

I understand that a \$25.00 fee will apply if I do not provide 24 hour notice for a missed or rescheduled appointment.

Name: _____ Date: _____