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1 PERSONAL AND CONTACT INFORMATION

FOR OFFICE USE ONLY

Date: _______________ Pt. No. _______

NAME: ____

Sex: ☐ M ☐ F Age: _________ Birthday: _________________

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? ____

2 MOTOR VEHICLE OR WORKPLACE ACCIDENT INFORMATION

Is your condition is 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:** _________________________

3

PATIENT CONDITION

Reason for Visit:

____

____

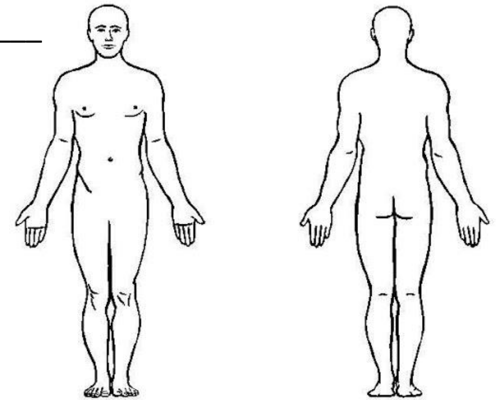
____

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:

☐ MRI Area of Body: _________________ Location of test: __________________ Date: ___________
☐ CT Area of Body: _________________ Location of test: __________________ Date: ___________
☐ X-ray Area of Body: _________________ Location of test: __________________ Date: ___________
☐ Ultrasound Area of Body: _________________ Location of test: __________________ Date: ___________

What other types of treatment have you had? ____

Notes:

Please move on to section 4

4 HEALTH HISTORY

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:

Please move on to section 5

5 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? $_________________

6 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: __________________________________