Cabana Chiropractic & HEALTH CENTRE

Chiropractic · Massage · Naturopathy · Osteopathy · Acupuncture

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1 PERSONAL INFORMATION

FOR OFFICE USE ONLY
Date: ____________ Patient Number ____________

Name: ______________________________

Sex: ☐ M ☐ F Age: ______ Birthday: ______________

Address: ____
Street name and number City Province Postal Code

Name of Medical Doctor: ______________________ Date of last MD visit: ______________

Whom may we thank for referring you today? ______________________________

2 CONTACT INFORMATION

Which number and time of day is best to reach you?

	Area Code		Morning	Afternoon	Evening
☐ Cell:	( )	______________	☐	☐	☐
☐ Home:	( )	______________	☐	☐	☐
☐ Work:	( )	____________ Ext ______	☐	☐	☐

Email: ______________________________

Emergency Contact Name: ______________________ Relationship: ______________

Emergency Contact Number: ( ) ______________________

3 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 4.

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#:** ______________________

4

PATIENT CONDITION

Reason for Visit: ____

____

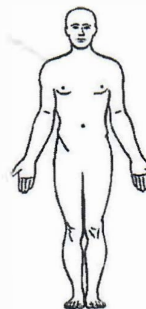
____

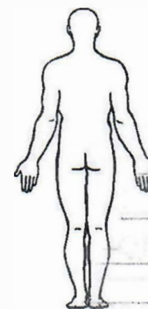
How did this happen? ____

____

____

Mark an X on the picture where you continue to have pain, numbness or tingling





When did your symptoms appear? ______________________

Is this condition getting worse? ☐ Yes ☐ No

Rate the severity of your pain on a 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 ☐ CT ☐ X-ray ☐ ultrasound

What other types of treatment have you had? ______________________

Notes:

Please move on to Section 5

5

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
- ☐ Stroke
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Varicose Veins

Respiratory

- ☐ Chronic Cough
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis

For Women

- ☐ Pregnant
  Due: ____________
- ☐ 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

Head and Neck

- ☐ Whiplash
  date: ____________
- ☐ Dizziness/fainting
- ☐ Headaches/migraines

Infections

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV
- ☐ Diabetes Type _____
- ☐ Other: ___________

Medication/Surgery

Recent Surgery:

1) ________________

____

Date: ____________

2) ________________

____

Date: ____________

Any other health concerns/conditions:

Medications:

____

____

____

____

Please move on to Section 6

6

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 date of first 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 date of first 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 Court Chiropractic, 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, knee braces, elbow braces and back 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 expenses
- 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)

Name: ______________________________________ Date: ______________________________