

PATIENT NUMBER

DATE

PERSONAL INFORMATION

MR MS DR
 FIRST NAME INT LAST NAME HOME PHONE
 STREET NUMBER AND NAME WORK PHONE EXT
 CITY POSTAL CODE COUNTRY CELL PHONE
 DATE OF BIRTH AGE EMERGENCY CONTACT RELATION EMERGENCY PHONE
 DD MM YY
 MARITAL STATUS
 SINGLE MARRIED DIVORCED SEP
 HOW DID YOU HEAR ABOUT US NAME OF PERSON
 WEB SIGN PERSON/MD OTHER

PLEASE COMPLETE BELOW

FAMILY HISTORY OF DISEASE			
CANCER	YES	NO	
STROKE	YES	NO	
DIABETES	YES	NO	
HYPERTENSION	YES	NO	
YOUR HISTORY			
ANEURYSM	YES	NO	
STROKE	YES	NO	
EPILEPSY	YES	NO	
HEART	YES	NO	
OSTEOPOROSIS	YES	NO	
BONE	YES	NO	
DIABETES	YES	NO	
CANCER	YES	NO	
BLOOD CLOTS	YES	NO	
BLEEDING	YES	NO	
HIGH/LOW BP	YES	NO	
ARTHRITIS	YES	NO	
NEUROLOGICAL	YES	NO	
DIZZINESS	YES	NO	
HEADACHES	YES	NO	
HIV POSITIVE	YES	NO	
PREGNANCY	YES	NO	
LIFE STYLE			
DO YOU SMOKE	YES	NO	
BIRTH CONTROL	YES	NO	
PLEASE LIST ALL THE SURGERIES YOU HAVE HAD IN THE PAST			
PLEASE LIST ANY MEDICATION/ VITAMINS YOU ARE CURRENTLY TAKING			

EMPLOYMENT INFORMATION

EMPLOYER CAN WE CALL YOU AT WORK
 YES NO
 EMPLOYER ADDRESS EMPLOYER CITY EMPLOYER P/C

EXTENDED HEALTH CARE INFORMATION

EXTENDED HEALTH CARE COMPANY GROUP NUMBER POLICY NUMBER/ID NUMBER

REFERRING PHYSICIAN INFORMATION

SPECIALIST PHYSICIAN PHONE NUMBER (IF KNOWN)-1

FAMILY PHYSICIAN INFORMATION

FAMILY PHYSICIAN PHONE NUMBER (IF KNOWN)

WSIB/MOTOR VEHICLE ACCIDENT CLAIMS (ONLY COMPLETE IF IT APPLIES)

ARE YOU MAKING A CLAIM FOR:
 MOTOR VEHICLE ACCIDENT WSIB (WORKPLACE ACCIDENT)
 HAVE YOU INJURED THIS AREA BEFORE?
 YES NO
 HEALTH CARD (OHIP) NUMBER VER NO
 EXPIRY DATE (DD/MM/YYYY)
 DATE OF ACCIDENT CLAIM NUMBER (IF KNOWN)
 BRIEFLY DESCRIBE WHAT HAPPENED

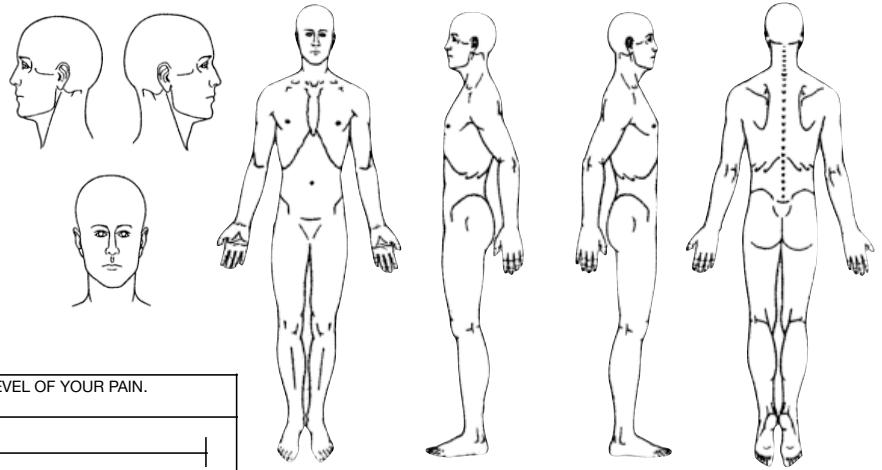
CHIEF COMPLAINT

PLEASE COMPLETE THE FOLLOWING

STEP 1

ON THE BODY TO THE RIGHT, USING THE SYMBOLS BELOW, PLEASE MARK THE LOCATION OF YOUR PRIMARY COMPLAINT

ACHE	BURNING	NUMBNESS	TINGLING	STABBING /SHARP	DEEP
XXXXX	+++++	AAAAA	*****	///////	-----



STEP 2

HOW DID YOUR SYMPTOMS START?	WHEN DID YOUR SYMPTOMS START
SUDDEN	0-3 MONTHS
GRADUAL	3-6 MONTHS
CAR ACCIDENT	6-9 MONTHS
WORK RELATED INJURY	1 YEAR OR MORE

STEP 3

IF YOUR DISCOMFORT IS PAIN, PLEASE MARK ON THE LINE BELOW, THE LEVEL OF YOUR PAIN.

0 (NO PAIN) WORSE PAIN (10)

OFFICE POLICIES

- SCHEDULING**
 - 1 Appointments during regular hours must be scheduled to reduce patient waiting time.
 - 2 Drops in are welcome, however all scheduled appointments will be seen first
 - 3 Cancellations require 12 hours notice to make the appointment available to other patients.
- PAYMENT**
 - 1 Payment is expected in full each visit, we accept Cash, Cheque, Interac Debit Card, and Visa
 - 2 NSF Cheques will be charged a \$15.00 fee
 - 3 Should you discontinue care for any reason, any outstanding balance will become due immediately and payable in full by you.
- FEES**
 - 1 The fee is payable in full at each visit
 - 2 Patients with health insurance plans, typically part of an employee benefit package are allowed to claim their patient fee for chiropractic services through their insurer.

INFORMED CONSENT TO RELEASE MEDICAL INFORMATION

I authorize any duly authorized representative of KGC Therapy

- To obtain copies of my medical records concerning any injury or illness related to my condition being treated
- Discuss and provide reports to my family physician, specialist, or surgeon
- Discuss and provide reports to Workman's Compensation Board
- Discuss and provide reports to my employer
- Discuss and provide reports to _____

A photocopy of this authorization may be accepted with the same authority as the original.

I have reviewed the above information that explains how your office will use my personal information and the steps your office is taking to protect my information.

I know that your office has a Privacy Code and I can ask to see the Code at any time.

I consent to receiving treatment at KGC Therapy as outlined by my treating Physiotherapist(s).

NAME (PLEASE PRINT) _____

SIGNATURE _____

DATED _____ 20____

SIGNATURE OF WITNESS _____