Patient Information

Date_____

Name_____ Sex: M/F
Address_____ Health card #_____
City_____ Postal Code_____
Phone (H)_____ (W)_____(C)_____
Occupation_____D.O.B_____
How did you hear about our office?_____

Health Information

Doctor's Name_____Phone Number_____
Address_____
Forward a copy of report Y/N

Name_____Phone Number_____
Address_____
Forward a copy of report Y/N

Name_____Phone Number_____
Address_____
Forward a copy of report Y/N

Reason for consulting this office_____
How long have you had this condition?_____
What makes the problem better? Heat_____Ice_____Nothing_____
Other_____
What makes the problem worse?_____
Have you previously sought treatment for this problem? Y/N
Describe:_____

Surgeries	**Injuries/Falls/Motor Vehicle Accidents**
Type:_____Date:_____	Type:_____Date:_____
Type:_____Date:_____	Type:_____Date:_____
Type:_____Date:_____	Type:_____Date:_____

Medications	**Lifestyle**
Prescriptions:_____ _____	Do You smoke? Y/N How much?_____
Over the counter:_____ _____	Do you drink coffee? Y/N How much?_____
Recreational:_____ _____	Do you consume alcohol? Y/N How much?_____