Patient Information			Date	
Name		Sex: M/F		
Address Health card #		t		
City		Postal Code		
Phone (H)	(W		(C)	
OccupationD.O.B		··		
How did you hear about our office?				
Health Informa	<u>tion</u>			
Doctor's Name		Phone Number		
Address				
Forward a copy o				
Torward a copy o	Topore 1714			
	mePhone Number			
Address	ddress			
Forward a copy o	of report Y/N			
Name	amePhone Number			
Address				
Forward a copy o	of report Y/N			
Reason for consulting this office				
How long have yo	ou had this condition?			
How long have you had this condition?IceNothing				
Other				
What makes the problem worse?				
Have you previously sought treatment for this problem? Y/N				
Surgeries		Injurie	Injuries/Falls/Motor Vehicle	
5u. gc. 165			Accidents	
Type:	Date:	Type:	Date:	
Type:	Date:	Type:	Date:	
туре:	Date	Type	Bate	
Type:	Date:		Date:	
Medications			Lifestyle	
Prescriptions:		Do You smo	V/N	
rrescriptions			Do You smoke? Y/N How much?	
		How indens		
Over the counter:		Do vou drin	Do you drink coffee? Y/N	
2.3. d. 6 66 d. 166 1			How much?	
		11077 11140111:_		
Recreational:		Do you cons	Do you consume alcohol? Y/N	
Neci cationari			How much?	