

PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Date of Birth *dd/mm/yyyy* _____ Age _____ Male / Female

Phone *Home* _____ *Work* _____ *ext* _____ *Cell* _____

Email _____

Marital Status: *S M D W Sep.* Spouse's Name _____ No. of Children _____

Closest Relative _____ Contact No. _____

How did you hear about our clinic? Check all that apply:

Friend (*Name*) _____ Colleague (*Name*) _____

Internet (*Google*) Internet (*activator.com*) Passing by Phone Book Other

Your Occupation _____ Employer _____

Address _____

Claim will be made against: Motor Vehicle Accident Insurance yes / no
Work related injury/accident yes / no
Health Insurance Benefits yes / no
(please note that we do not direct bill insurance for you)

Medical Doctor's Name _____ Clinic _____

Address _____ Phone _____

Date of Last Appointment _____ Date of Last Physical _____

HEALTH HISTORY

Name _____ Date _____

Have you ever had:

- Measles Chicken Pox Whooping Cough Scarlet Fever Diphtheria Mumps
- Rheumatic Fever Typhoid Fever Chronic Illness Tubes in Ears Aneurysm
- Osteoporosis Diabetes Arthritis Heart Condition Epilepsy Stroke Hepatitis
- Anxiety Breathing Condition Polio Pneumonia Pleurisy Asthma
- Sinus Infections Psoriasis HIV/AIDS VD Fatigue
- Allergies _____
- Cancer _____

Have you had previous Chiropractic care?

Name _____ City _____
Results _____

Have you ever had X-rays taken? Yes / No _____
Results / findings: _____

- Smoking _____ cig/day Coffee _____ cups/day Water _____ glasses/day
- Alcohol _____ oz/week Meals _____ /day
- Exercise _____ # days/week What type of exercise _____

Medications and/or Supplements: _____

Family History (please circle):

Diabetes Heart Disease Cancer Low Back Pain Neck Pain Headaches Stroke

Have you been in an auto accident in the last 20 years? Yes / No

Have you had any slips/falls/concussions in your lifetime? Yes / No

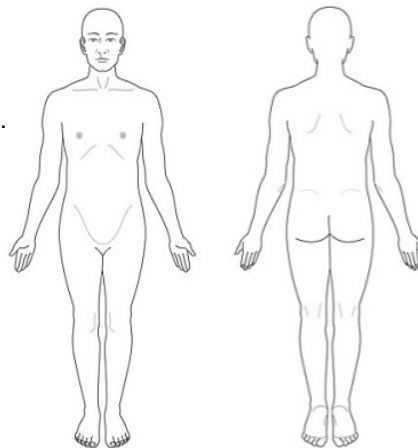
Reason for consulting this office: _____

Expectations: _____

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

- Numbness ●●● Pins & Needles OOO
- Burning XXX Aching ★★★
- Stabbing +++



OFFICE POLICY

Welcome to King West Chiropractic Health Centre. Please take a few moments to read over our Office Policy. We will be happy to answer any questions you may have regarding this policy or other clinic procedures.

Clinic Hours: Monday to Friday, 8:00 am to 6:30 pm

Chiropractic Fee Schedule*

| | |
|--|--------|
| Initial Examination (<i>Chiropractic / Acupuncture / Foot Orthotics</i>) | 78.00 |
| Adjustment | 45.00 |
| Acupuncture | 50.00 |
| One pair of Custom Foot Orthotics | 475.00 |
| Second pair of Custom Foot Orthotics (<i>if ordered on the same day</i>) | 275.00 |
| One pair of Orthotic Shoes | 550.00 |

Massage Therapy Fee Schedule*

| | |
|------------------|---------------------|
| 30 min treatment | 55.00 + <i>hst</i> |
| 45 min treatment | 69.00 + <i>hst</i> |
| 60 min treatment | 89.00 + <i>hst</i> |
| 75 min treatment | 112.00 + <i>hst</i> |
| 90 min treatment | 125.00 + <i>hst</i> |

Osteopathy Fee Schedule*

| | |
|-----------------------------|--------|
| 60 min initial treatment | 140.00 |
| 45 min subsequent treatment | 110.00 |

**All rates subject to change.*

Insurance

Many benefit plans cover some or all of our services. While our office does not deal directly with insurance companies, we do issue official receipts which may be submitted for reimbursement.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when canceling or rescheduling massage/osteopathic appointments.

If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.

*** KWC is a scent-free clinic – please refrain from wearing perfume or cologne ***

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your account and clinic updates/promotions.

Please check this box if you consent to receiving our clinic newsletter (sent by email once per month).

Email _____

Patient Signature _____

Date _____