CHAMPION CHIROPRACTIC
& WELLNESS CENTRE

Date: _____

**Please tell us about yourself:**

First Name: _____ Last Name:_____

Date of Birth: Day:_____ Month: _____ Year: _____ Gender: M o F o

Address: _____

City: _____ Postal Code: _____

Telephone: Home: _____

*Leave message Yes* o *No* o *Do Not Call* o

Cell/Work Telephone: _____

*Leave message Yes* o *No* o *Do Not Call* o

Email Address: _____

*Include me in future emails regarding events and information: Yes* o *No* o

What is your occupation? _____

Emergency Contact: _____ Telephone: _____

Relationship: _____

**Previous Chiropractic Experience:**

Previous Chiropractors Name: _____

Date of Last Chiropractic Visit: _____

Medical Doctors Name: _____

Medical Doctors Telephone: _____

**How did you hear about us?**

Newspaper o Internet o Yellow pages o

Friend/Relative o Signage o Other: _____

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**Billing Information:**

Is this a Workplace Safety & Insurance Board Injury (WSIB): Yes o No o

*If yes, please fill out the following information*

WSIB Claim Number: _____ Date of Accident: _____

Employer's Name: _____

Employer's Address and Telephone: _____

Are your injuries related to a motor vehicle accident? Yes o No o

*If yes, please fill out the following information*

Date of Accident: _____

Insurer's Name: _____

Policy or Claim Number: _____

Insurer's Address and Telephone: _____

**Fee Schedule:**

Initial Visit: $70

Subsequent Visit: $40

Senior/Student/Child Subsequent Visit: $35

Home Visit: $60

**Consent:**

I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

Date: _____ Guardian: _____

*If patient is under 18 years of age*

Name: _____
Date: _____

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**Personal Medical History**

Please mark an 'X' for any conditions or symptoms you are experiencing ***currently***
Please mark a '√' for any conditions or symptoms you have experienced in the ***past***

| | | |
|---|---|---|
| ❑ Allergies | ❑ Difficulty Breathing | ❑ Low bone density |
| ❑ Angina | ❑ Digestion issues | ❑ Nausea |
| ❑ Arthritis | ❑ Dizziness | ❑ Night Sweats |
| ❑ Blackouts/Loss of consciousness | ❑ Epilepsy | ❑ Numbness and tingling |
| ❑ Bleeding Disorder | ❑ Excessive hunger or thirst | ❑ Osteoporosis |
| ❑ Blood in Urine | ❑ Fainting | ❑ Problem Speaking |
| ❑ Blurred/Double/Failing Vision | ❑ Fever | ❑ Problem swallowing |
| ❑ Bowel/Bladder Disorders | ❑ Headaches | ❑ Rashes/Itching |
| ❑ Cancer | ❑ Hearing problems | ❑ Ringing in the ears |
| ❑ Chest Pain | ❑ Heart Attack | ❑ Spitting up blood |
| ❑ Chronic Cough | ❑ High Blood Pressure | ❑ Stroke/TIA |
| ❑ Circulatory Problems | ❑ High Cholesterol | ❑ Swelling of ankles/joints |
| ❑ Clumsiness | ❑ Kidney Issues | ❑ Tremors |
| ❑ Concussions | ❑ Loss of Sleep | ❑ Varicose Veins |
| ❑ Depression or Anxiety | ❑ Loss of Strength | ❑ Weight loss/gain |
| ❑ Diabetes | | |

## Family Medical History

**Please check if you or anyone in your family have any of the following**:

- ❑ Cancer: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ Heart Disease: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ Stroke: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ Diabetes: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ Hypertension: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ High Cholesterol: ___Myself ___Mother ___Father ___Sibling ___Other: _____
- ❑ Other Conditions: _____

**WOMEN**: Are you currently pregnant? □ Yes □ No # Pregnancies:____ # Children: ____
Are you on birth control pill/patch? □ Yes □ No □ Previously How Long?: _____

Please list any medications and supplements you are currently taking, and their doses:

1. _____ 4._____
2. _____ 5. _____
3. _____ 6. _____

Previous Fractures & When: _____
Previous Imaging (x-ray, MRI, CT, etc):_____
Previous surgeries/hospitalizations & when:_____
Previous car accidents & when:_____
Are you currently a smoker? □ Yes □ No □ Previously

Name: _____
Date: _____

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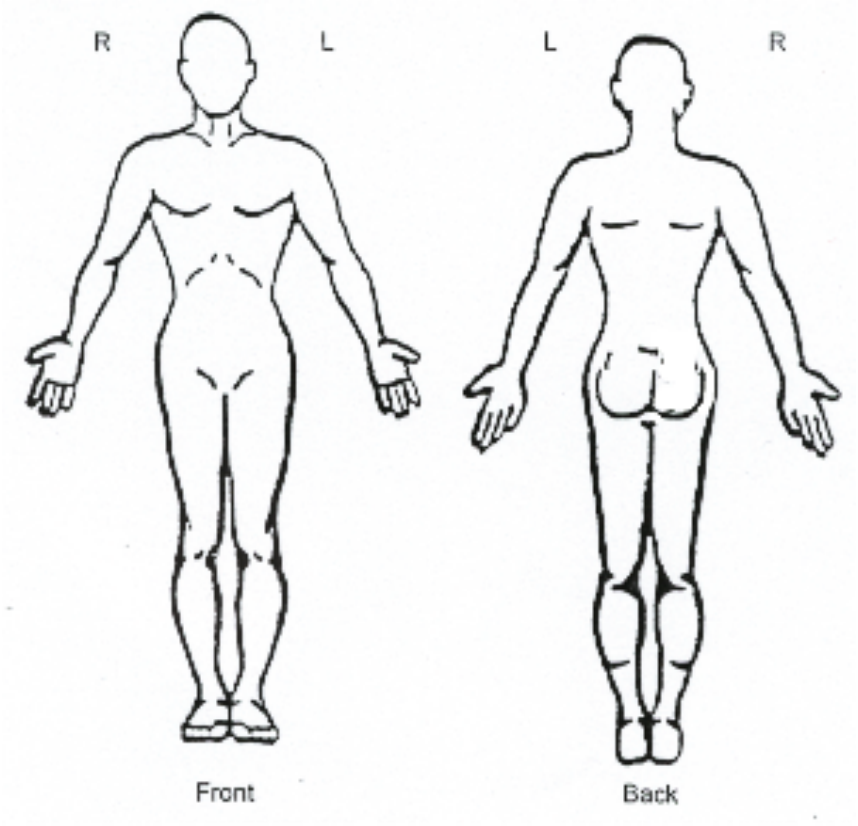
What is your primary complaint? _____

Please mark the location of your pain on the diagram below using the following:

Numbness: = = =
Pins & Needles: N N N
Burning: x x x
Sharp & Stabbing: s s s
Dull & Aching: o o o
Stiff & Tight: 2 2 2





How severe is the pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Excruciating