New Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ⋮ **Gender (Circle):** M / F / Prefer not to say ⋮ **Date of Birth (D/M/Y):**_____/_____/_____

First Name:_____ **Last Name:**_____

Address: (Street)_____ (Apt#)/Unit_____

(City)_____ (Province)_____ (Postal Code)_____

Residence Phone: (_____)_____-_____

Cell Phone:_____(_____)_____-_____

Email Address: _____

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact Number: _____(_____)_____-_____

Family Doctor Information

Family Doctor: _____

Address: _____

City_____

Phone: _____

Fax: _____

Referral Information

Referred For: ◯ Physio, ◯ Chiro, ◯ RMT ◯ Sports Psych

Referred by: _____

Address: _____

City: _____ Postal:_____

Phone: _____

Fax: _____

Is this a Work or Motor Vehicle Injury? ☐ Yes ☐ No *(If not, you do NOT need to fill in the following information)*

MVA / WSIB claim and policy number?		Date of loss/accident (D/M/Y):	
Insurance/Employer's name:		Insurance/Employer's Company and Address:	
Adjuster/Employers Telephone:			

Patient Agreement:

1. I understand that is my responsibility to provide accurate and current information about my medical history.

2. I understand and acknowledge the fees for services rendered by any provider of the Royal Chiropractic and Sports Injury Clinic

3. I understand it is my responsibility to cover the full cost of the treatment. If I have extended benefits I will pay on the days of service and seek reimbursement through the insurance company. In the event that I am attending the clinic due to injuries sustained in a motor vehicle accident and the insurance is billed on my behalf, I will remit all payments received for services rendered to the Royal Chiropractic and Sports Injury Clinic.

4. I acknowledge the late outstanding balances must be paid prior to my discharge from a treatment program

5. I acknowledge the late cancellation and missed appointments policy. I agree to pay for the time blocked off for me should I not provide 24 or more hours-notice.

6. I hereby direct and authorize the Royal Chiropractic and Sports Injury Clinic to exchange my medical file and health information with my Medical Providers.

Patient/Guardian's Name: _____

Date of Intake: _____ **Signature:** _____

New Patient Information

Patient Medical History

Do you have any of the following cardiovascular issues?

	Yes	No
Blood Pressure (high/low)	◯	◯
Cholesterol (high/low)	◯	◯
Palpitations	◯	◯
History of heart disease or stroke	◯	◯
Implanted pacemaker or similar device	◯	◯

Do you have any of the following pulmonary issues?

	Yes	No
Do you smoke?	◯	◯
If Yes, how long?		
Asthma	◯	◯
History of bronchitis/pneumonia	◯	◯

Do you have any of these medical issues?

	Yes	No
Bleeding Disorders (i.e. hemophilia, sickly cell, etc.)	◯	◯
Diabetes – Type I or II	◯	◯
Implanted pacemakers or similar device	◯	◯
Bowel or bladder problems	◯	◯
Previous history of cancer	◯	◯
Currently Pregnant of Possible pregnant	◯	◯
Headaches	◯	◯
Dizziness	◯	◯
Difficulty Speaking	◯	◯
Double Vision	◯	◯
Difficulty Swallowing	◯	◯
Suddenly Falling (ie. legs giving out)	◯	◯

Previous Surgeries ◯ Yes ◯ No

If Yes, please list:

_____

_____

List any previous injuries and when they were sustained:

_____

_____

Are you taking any medications, if so please list:

_____

_____

History of Concussion(s) (Please include dates if possible):

_____

_____