CENTRUM
CHIROPRACTIC

Centrum Chiropractic Clinic
210 Centrum Blvd., Suite 116
Orleans ON K1E3V7
613-830-4080

PERSONAL INFORMATION:

Name: ____ **Date**: _______________

Age: ___________ **Email Address**: ____

Gender: _____________ **Date of Birth**: _________________

Address: ______________________________________ **City**: _____________________

Postal Code: ________________________ **Home Phone**: ________________________

Work Phone: ______________________ **Cell Phone**: __________________________

Marital Status: ________________________ **Occupation**: ______________________

Number of Children and Ages: ____

How did you hear about us? If from a patient, who may we thank for referring you?

____

What is the name of your primary physician? _________________________________

May we have permission to keep your physician up to date with our doctor's findings?

Yes____ No ____

Are you covered by insurance? Yes___ No___

Emergency Contact:

Name__________________________________ Phone Number___________________

HEALTH PROFILE:

Why is this form necessary?

Our focus is on assisting people to function optimally to become more self-aware, stronger and healthier, and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time; contributing to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

What brings you to our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints, and are here for wellness services, please indicate so, and skip to the general history section.

____

____

Please rate the severity of your health concerns from 1-10 where 1=mild and 10=worst imaginable.

____

When did this start? _________________________

Did the problem begin with injury? Yes___ No___

Are the symptoms constant or intermittent? ___________________________________

Since your major problem started, it is:
The Same_____ Getting Better _____ Worse_____

What, if anything makes it feel better? ____

Does this interfere with your work, leisure, sleep, sports, or anything else?

____

Have you seen other doctors for this condition?

____Chiropractor ____Medical Dr. ____Other

If so, please give us:

Their Name/Address

____

Date of Visit: _____________________ Diagnosis: ______________________

GENERAL HISTORY:

Please list all medications you are taking and why (prescription and non-prescriptions:

____

Have you ever had any surgeries or hospitalizations (your entire life)?

____

____

Have you ever had any work-related injuries? ___________________________________

Have you ever had any slips, falls, or automobile accidents?

____

____

Please circle all symptoms, or health concerns you have ever had, even if they do not seem related to your current problem:

Pins & needles in arms	Constipation	Loss of Balance	High Cholesterol
Dizziness	Lights Bother Eyes	Nervousness	Hernia
Numbness in fingers	Menstrual Pain	Stomach Upset	Fertility Problems
Fatigue	Fainting	Tension	Osteoporosis
Sleeping Problems	Back Pain	Cold Feet	Stroke
Diarrhea	Ringing in Ears	Hot Flashes	Ulcerative Colitis
Cold Sweats	Loss of Taste	Heartburn	Headaches
Mood Swings	Irritability	Ulcers	
Loss of Smell	Cold Hands	Allergies	
Buzzing in Ears	Fever	Asthma	
Numbness in Toes	Urinary Problems	Cancer	
Depression	Menstrual Irregularity	Hypertension	
Stiff Neck	Neck Pain	Diabetes	

On a scale of 1-10, describe your psychological/emotional stress levels where 1=none and 10=extreme: work________________________ personal_______________________

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating Habits: ____ Exercise Habits: ____ Sleep: ____ General Health: ____

Mind-set: ____

Have you ever (please circle):

Bought bottled water	Yes	No
Belonged to a health club	Yes	No
Consumed vitamins or supplements	Yes	No
If there is a need for dietary changes, would you like to know?	Yes	No
If there is a need for specific exercises, would you like to know?	Yes	No
If there is a need for support in the psychological/mind/body/stress dimensions of health, would you like assistance?	Yes	No

YOUR GOALS:

At our office, we care about YOUR Health and Wellness GOALS. Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional Goals	Psychological Goals
_____________________	____________________	_____________________
_____________________	____________________	_____________________
_____________________	____________________	_____________________

Prices* for our services are as follows:

Adult Adjustment	$45
Child Adjustment	$20
Senior/Student Adjustment	$35
Acupuncture	$50
Progress Exam (after 20 treatments)	$0
Comparative Exam (every 20 treatments	$25
Re-evaluation fee (1 years or longer)	$75

New Patient Exam $95 + price of adjustment or acupuncture

By signing below, you accept and acknowledge the responsibility of payment for services rendered as scheduled and agreed upon and consent to an examination. In the event your insurance does not cover the costs of your care you will still be fully responsible for any outstanding balance incurred as a result.

I hereby give my consent for a chiropractic examination to be performed.

Patient Signature: ______________________________ Date: ____________________

*All prices are subject to change without notice. Ask us how you can get free adjustments!