DI NATALE
CHIROPRACTIC
+ SPORTS THERAPY

Dr. Christopher Di Natale D.C

13831 Riverside Dr. E., Unit #3
Windsor, ON, N8N 1B5

T: (519) 960 0360
F: (519) 960 0361

CONFIDENTIAL PATIENT HEALTH HISTORY

Full Name:

Date of Birth:
(Year/Month/Day)

Gender: ☐ Male ☐ Female ☐Other

ADDRESS: _____

City: _____

Postal Code: _____

TELEPHONE NUMBER:

Primary Phone: _____

Secondary Phone: _____

EMAIL ADDRESS: _____

PREFERRED CONTACT: *(Appointment Reminders)* ☐ Text Message ☐ Email

CURRENT EMPLOYMENT: _____

MARITAL STATUS: *(Please Check)*

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

FAMILY PHYSICIAN: _____

HOW WERE YOU REFERRED TO OUR CLINIC?

☐ Doctor _____ ☐ Friends/Family: _____ ☐ Internet _____

☐ Other _____

HAVE YOU PREVIOUSLY RECEIVED CHIROPRACTIC CARE? ☐ YES ☐ NO

If YES, Please Specify: From Who: _____ When: _____

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PATIENT HEALTH HISTORY AND CHIEF COMPLAINT

Please indicate where you feel your pain/discomfort: _____

How and when did this problem begin? _____

Is this a reoccurrence of a problem you have had before? ☐ YES ☐ NO

Have you had recent or past imaging of the painful region? ☐ YES ☐ NO
If YES, please specify type and date performed: _____

How would you describe your condition/pain?

☐ SHARP ☐ STABBING ☐ STIFF ☐ ACHING ☐ OTHER _____

Does your pain travel anywhere else? ☐ YES ☐ NO
If YES, please specify: _____

Do you experience any of the following in your arms or legs?

☐ NUMBNESS ☐ TINGLING ☐ WEAKNESS

Does coughing, sneezing or bearing down aggravate your problem? ☐ YES ☐ NO

When is your pain the worst? ☐ MORNING ☐ MID-DAY ☐ NIGHT ☐ NO CHANGE

On the scale below, rate the intensity of your pain using an “X”:

0 _____ 5 _____ 10
(*No Pain*) *(Severe)*

Is your problem: ☐ CONSTANT ☐ INTERMITTANT ☐ WORSE WITH MOVEMENT

Has your problem worsened since the initial onset? ☐ YES ☐ NO

What aggravates your condition: _____

What relieves your condition: _____

Do you perform or maintain prolonged positions at work? ☐ YES ☐ NO

Secondary Complaints: _____

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PERSONAL & FAMILY HEALTH HISTORY

Please check all that apply	**Self**	**Father Side**	**Mother Side**
CANCER	☐	☐	☐
HEART DISEASE	☐	☐	☐
STROKE	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐
DIABETES	☐	☐	☐
ARTHRITIS	☐	☐	☐
NEUROLOGICAL DISORDER	☐	☐	☐
OSTEOPOROSIS/ BONE DISEASE	☐	☐	☐
THYROID IMBALANCE	☐	☐	☐
OTHER DISEASES:			

Have you had any significant previous accidents or injuries? Please provide dates and details:

List all medications/supplements you are currently taking:

ALLERGIES

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HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/wk for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/wk for 30 minutes)					
Diet	Are you dieting?			☐ Yes	☐ No	
	If Yes, Please Specify:					
	Number of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	Number of cups/cans per day?					
Alcohol	Do you drink alcohol?			☐ Yes	☐ No	
	How many drinks per week?					
Tobacco	Do you use tobacco?			☐ Yes	☐ No	
	☐ Cigarettes – pks./day	☐ Chew – Number/day	☐ Pipe Number/day	☐ Cigars Number/day		
	___ Number of years	___ Or year quit				
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No		

Is stress a major problem for you?	☐ Yes ☐ No
Do you feel unhappy, depressed or lethargic?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Any recent changes to your usual sleep pattern?	☐ Yes ☐ No
Any recent changes to your usual bowel or bladder movements?	☐ Yes ☐ No
Have you recently gained or lost weight, unexpectedly?	☐ Yes ☐ No

Current Weight: _____ Current Height: _____

FEMALE PATIENTS ONLY

Does your pain increase at certain times during your menstrual cycle?	☐ Yes ☐ No
Do you suspect being pregnant at this time?	☐ Yes ☐ No

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BENEFIT ASSIGNMENT FORM – INSURANCE INFORMATION

We currently **bill directly** to the following insurance companies: ***Photocopy of card is required.***

Green Shield	☐ Yes	Great West Life	☐ Yes	Sun Life	☐ Yes
Blue Cross	☐ Yes	Manulife	☐ Yes	Johnson	☐ Yes
Desjardins	☐ Yes	Industrial Alliance	☐ Yes	Chambers of Commerce	☐ Yes
RWAM	☐ Yes	Other: *(Please Specify)*			

Patient Name: _____
Address: _____
Address: _____
City: _____
Postal Code: _____
Phone Number: _____
Insurance Company: _____
Plan/Policy #: _____
Certificate/ID #: _____

I hereby assign benefits payable for the eligible claims to Di Natale Chiropractic + Sports Therapy responsible for submitting my claims electronically to the groups benefits plan. I authorize the insurer/plan administrator to issue payment directly to Di Natale Chiropractic + Sports Therapy. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to Di Natale Chiropractic + Sports Therapy for any services rendered and/or supplies provided.

I acknowledge and agree the insurer/plan administrator is under no obligation to accept this assignment. Any benefit payment made in accordance with this agreement will discharge the insurer/plan administrator of its obligations with respect to that benefit payment. In the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by Di Natale Chiropractic + Sports Therapy and that I may revoke at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to Di Natale Chiropractic + Sports Therapy.

Signature: _____ Date: _____

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Consent for Physical Examination:

I, _____ , hereby consent for my initiating chiropractor to perform a physical examination of the region and associated regions of my chief and secondary complaints.

Signature: _____ Date: _____

Please Read Carefully and Sign

I am aware that it is my responsibility to cover all fees for services and/or products rendered by Di Natale Chiropractic + Sports Therapy and will do so upon request. I am further aware that it is office policy to charge for missed appointments (unless 24 hour notice is given). Missed appointment fees will be charged at a rate equal to the cost of the visit that is missed.

Signature: _____ Date: _____