



152 Lesperance Rd., Unit #3
Tecumseh, ON, N8N 1W1

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

CONFIDENTIAL PATIENT HEALTH HISTORY

Full Name: _____
Date of Birth: (Year/Month/Day) _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
ADDRESS: _____
City: _____
Postal Code: _____
TELEPHONE NUMBER:
Primary Phone: _____
Secondary Phone: _____
EMAIL ADDRESS: _____
PREFERRED CONTACT: (Appointment Reminders) <input type="checkbox"/> Text Message <input type="checkbox"/> Email
CURRENT EMPLOYMENT: _____
MARITAL STATUS: (Please Check)
<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
FAMILY PHYSICIAN: _____
HOW WERE YOU REFERRED TO OUR CLINIC?
<input type="checkbox"/> Doctor _____ <input type="checkbox"/> Friends/Family: _____ <input type="checkbox"/> Internet _____
<input type="checkbox"/> Other _____
HAVE YOU PREVIOUSLY RECEIVED CHIROPRACTIC CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, Please Specify: From Who: _____ When: _____

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: _____

PERSONAL & FAMILY HEALTH HISTORY

<i>Please check all that apply</i>	Self	Father Side	Mother Side
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OSTEOPOROSIS/ BONE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID IMBALANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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

HEALTH HABITS AND PERSONAL SAFETY

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

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

Current Weight: _____

Current Height: _____

FEMALE PATIENTS ONLY

Does your pain increase at certain times during your menstrual cycle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suspect being pregnant at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	Yes	Great West Life	<input type="checkbox"/>	Yes	Sun Life	<input type="checkbox"/>	Yes
Blue Cross	<input type="checkbox"/>	Yes	Manulife	<input type="checkbox"/>	Yes	Johnson	<input type="checkbox"/>	Yes
Desjardins	<input type="checkbox"/>	Yes	Industrial Alliance	<input type="checkbox"/>	Yes	Chambers of Commerce	<input type="checkbox"/>	Yes
RWAM	<input type="checkbox"/>	Yes	Other: <i>(Please Specify)</i>					

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 + Wellness 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 + Wellness. 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 + Wellness 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 + Wellness 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 + Wellness.

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 + Wellness 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: _____