



1002 King St. W. Toronto, ON M6K 3N2
416-597-1604

GENERAL PATIENT INFORMATION

Name: _____ Gender: _____ Date of Birth: _____
M/F MM/DD/YY

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Bus.Tel: _____ Alt. Tel: _____

Emergency Contact: _____ Tel: _____ Relation: _____

E-mail Address: _____@_____

Would you like to receive a reminder for your subsequent appointments? Email / Phone

How did you hear about our clinic?	Yellow Pages	Website	Walk- in
	Friend (who?) _____		Mailout
	Brochure	Other _____	

Name of Medical Doctor: _____ Tel: _____

Address _____

Date of last appointment: _____ Date of last physical: _____

Are you taking any medications? If so, what? _____

Permission to consult with the above Health Care Providers Yes/No

I (please print name), _____, give permission to the discussion of any of the information in this form amongst the Health Care Team at King West Village Chiropractic Clinic.

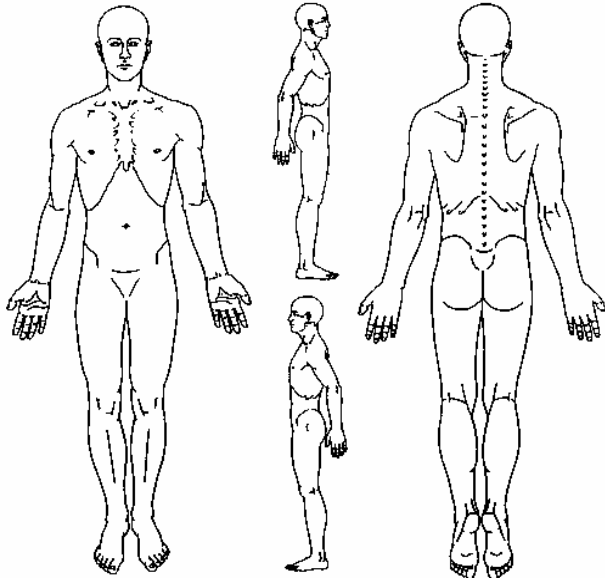
Signature: _____ Date: _____
(guardian if under 18)

INITIAL INTAKE FORM

Name: _____

Date: _____

Reason for consulting this office _____



Onset: Insidious Sudden

Mechanism of Injury: _____

Pain Character:

Ache

Sharp/Stabbing

Other _____

Duration: Constant Intermittent

Pattern: Morning Day Night

Pain Intensity: Now ___/10 Last Week ___/10

Radiation Y N

Type

Ache

Pins/Needles

Numbness

Burning

Sharp/Stabbing

Other _____

Aggravating Factors:

Prolonged Sitting

Prolonged Standing

Prolonged Walking

Coughing/Sneezing

Bending

Repetitive movements

Swallow/strain

Other _____

Associated Symptoms

Saddle Paraesthesia

Bowel/Bladder

Night Pain

Recent Weight Loss

Fever

Hx of corticosteroids

Nausea/Dizziness

Headaches

Relieving Factors:

Rest

Medication _____

Certain Posture _____

Movement _____

Other _____

Do you have or have you ever had any of the following?

Diabetes	Heart trouble	Allergies to cold
Metal Implants	Headaches	Seizures
Nervous disorder	Allergies to heat	Hepatitis
Other allergies	Previous surgery	Cancer
Dizziness	Are you pregnant?	Stroke
HIV/Aids	Pacemaker Kidney problems	Hernias

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of Chiropractic named below.

I have had an opportunity to discuss with the doctor of Chiropractic named below and/or with other office or clinic personnel, the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care in the practice of Chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

*Stroke_ recent research has shown that the risk of stroke is one in one million.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above mentioned Chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition.

I understand that I am responsible for the fee of each treatment at the completion of each treatment.

A 24 hours notice is required to cancel an appointment, otherwise you will be billed a missed appointment charge.

To be completed by the patient:

 print patient's name

 signature of patient

date signed _____