# ANDERS VICTORIA FAMILY CHIROPRACTIC
## New Patient Intake

## PERSONAL INFORMATION

| | | | | |
|---|---|---|---|---|
| Title: ☐Mr. ☐Mrs. ☐Miss ☐Dr. | | Gender: ☐Male ☐Female | | Date: |
| First Name | Initial | Last Name | | Alberta Health Care #: |
| Street Address: | City: | Province: | Postal Code: | Email: |
| Home Phone Number: | Cell Phone Number: | | Emergency Contact Name & Phone Number | |
| Birthday (Month/Day/Year) | Spouse's Name | # of Children | Occupation: Is this a work related injury? | |

How did you hear about us? ☐Yellow Pages ☐Website ☐Facebook ☐Referred By:

## MEDICAL AND CHIROPRACTIC INFORMATION

| | | | |
|---|---|---|---|
| Name of Medical Doctor | Last Visit | City | List Allergies: |

What is Your Reason for Seeking Chiropractic Today?

| | | |
|---|---|---|
| How Long Have You Been Experiencing This? | Have You Received Previous Treatment? ☐Yes ☐No | What Was the Treatment? |
| Have You Had Previous Chiropractic Care? ☐Yes ☐No *(If yes, complete the following)* | Name of Previous Chiropractor | Last Visit |
| Reason For Seeking Care: | | Results ☐Good ☐Fair ☐Poor |

## MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

**Please check all that apply:**

☐ Fatigue
☐ Dizziness
☐ Weakness in arms
☐ Weakness in legs
☐ Numbness in arms
☐ Numbness in legs
☐ Headaches
☐ Neck pain
☐ Upper back pain
☐ Low back pain
☐ Arm pain
☐ Leg pain
☐ Constipation
☐ Diarrhea
☐ Swelling of joints
☐ Poor concentration
☐ Hearing loss/Ringing
☐ Other:_____

☐ Weight gain
☐ Weight loss
☐ High blood pressure
☐ Elevated cholesterol
☐ Diabetes
☐ Cancer
☐ Arthritis
☐ Heartburn
☐ Loss of sleep
☐ Vision loss/changes
☐ Difficulty breathing
☐ Asthma
☐ Nausea
☐ Poor control of bowel/bladder
☐ Frequent urination
☐ Depression
☐ Auto-Immune Disease

**Family History:**
□Cancer
□Stroke
□Diabetes
□Hypertension
□Other:_____
_____

**Social History**
□Smoke
□Alcohol
□Caffeine
□Current Exercise Level
_____
_____

Please list all the **surgeries** you have had in the past:

_____
_____
_____

Please list all the **medications and vitamins/supplements** you are currently taking:

_____
_____
_____

**For Women Only**:

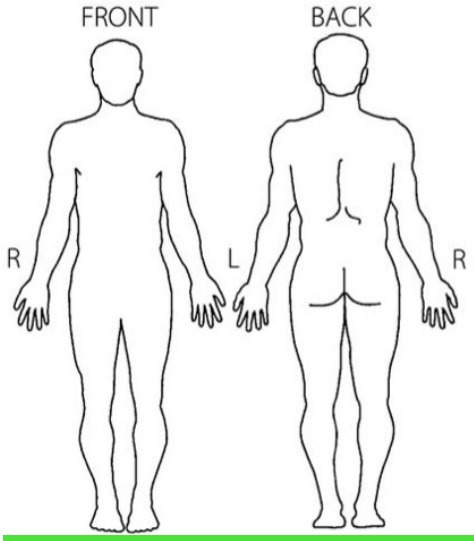
Are you Pregnant? ☐Yes ☐No Due Date:_____
□ Menstrual pain □ Mood disturbance
□ Irregular cycle □ Menopause
□ Hot flashes

What type of care interests you?
□Pain relief
□Regular Chiropractic and Wellness care to prevent injury, sickness, and disease and to live to my full potential

Please Turn Over

Name: Date:

## CHIEF COMPLAINT




1

**HOW TO COMPLETE THIS DIAGRAM**

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

| Ache | Burning | Numbness | Tingling | Stabbing/Sharp | Deep |
|---|---|---|---|---|---|
| XXXX | ++++++ | ^^^^^^ | ******* | ////////// | ====== |

2

How did your symptoms start?

- ☐ sudden
- ☐ gradual
- ☐ car accident
- ☐ work related injury

When did your symptoms start?

- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

3

Please mark on the line below the level of your discomfort.

0 — 10
no pain — worst pain

## OFFICE POLICY AND FEE SCHEDULE

Welcome to our clinic! We want our office environment to be as positive and constructive as possible, to maximize the healing potential for our patients. Here are a few guidelines and some information to ensure your visits to the office run smoothly.

- Please help us keep our clinic clean by removing wet or muddy footwear when you enter the office.

Scheduling

- We encourage all appointments to be scheduled before hand to reduce patient waiting time.
- Drop-ins are welcomed, but scheduled patients will be seen first.
- **Cancellation notice** - We value your time and expect that you likewise respect the doctor's time by making every effort to notify us in the event that you have to miss an appointment. We understand that unforeseen events may make it difficult for you to make your appointment, but **we appreciate advanced notice if you need to reschedule your treatment. Repeated violations of this request may result in a charge for the full amount of the missed treatment.**

Payment

- Payment is expected in full for each visit. We accept Cash, Cheque, Debit, Visa, Master Card
- Direct Billing is available for most insurance companies
- Should you discontinue treatment, any outstanding balance will become due immediately and payable in full by you

Fees

| **Adult Patients** | | **Child Patients** | | **Other Services** | |
|---|---|---|---|---|---|
| Initial Consultation | $90.00 | Initial Consultation (Under 18) | $80 | Custom Orthotics | $375 |
| Adjustments | $50.00 | Student Adjustments (13 and older) | $40 | After hours/Emergency | $60 |
| | | Adjustments (0-12) | $35 | Supplements – as seen | |

Current Promotions:

- The last Thursday of every month is Senior's Day. All patients that are 65 years of age and older can get treated for $35
- The first week of every month is Family Week. If the whole family attends, adults will receive treatment for $40 each

**Referrals** – Our practice grows through referrals from satisfied patients. We encourage and appreciate when patients are so happy with their treatments that they bring in their friends and family!

With this signature, I declare that I have read and understand the terms and conditions of Anders Victoria Family Chiropractic.

Date: _____

_____ _____

(Print Name) (Signature of Patient or Parent/Legal Guardian)