

Welcome To Scott Family Chiropractic
 8 Lansdowne Ave., Woodbridge, Ontario L4L 2A9
Tell us about yourself
(Please print clearly)

Name: _____ Date: _____
 (Surname) (First Name)

Address: _____

Home Phone: _____ Bus. Phone: _____

Date of Birth: _____ Occupation: _____

Who referred you? _____

What is your primary complaint? _____

Health History: Please indicate conditions you are experiencing, or have experienced.

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

Other Conditions

- loss of sensation
- diabetes (onset: _____)
- allergies (ie: anaphylaxis)
- epilepsy
- cancer
- arthritis

Women

- pregnant (due: _____)

Soft tissue/joint discomfort and its nature

- neck
- low back
- mid back
- upper back
- shoulders
- arms
- legs
- knees
- other

Cardio vascular

- high blood pressure
- low blood pressure
- CCHF
- heart attack
- phlebitis
- stroke/CVA
- pacemaker or similar device

Head/ Neck

- vision problems
- vision loss
- ear problems
- hearing loss

Skin

- skin conditions

Infections

- hepatitis
- skin conditions
- TB
- HIV

Current Medications: _____ Primary Care Physician: _____

Condition it treats: _____ Address: _____

Surgery: _____ Date: _____ Present involvement in other health care Yes No

Nature: _____ If yes specify: _____

Injury: _____ Date: _____

Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.): _____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

Please read and sign the following:

All appointments for massage are to be booked at the front desk.

All first appointments require a full hour to have a proper assessment.

Cancellations must be made 24 hours in advance. Patients who regularly cancel at the last minutes, or miss appointments without canceling in advance will be charge a regular appointment fee.

NSF Cheques will be charge an additional \$20.00 on top of regular fee.

Insurance Coverage, we will be happy to provide you with receipts that you may forward to your insurance company.

Late arrivals will not exceed the allotted scheduled time and full fee will be charge.

Payment is due at time of service.

I have read the above consent and policies

I have also had an opportunity to ask questions about its content and by signing below I Agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions.

Patient Signature: _____ Date: _____

Witness Signature (C.H.A.) _____ Date: _____

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(905) 264-KIDS (5437)