STONEBRIDGE CHIROPRACTIC

1 YEAR + CHIROPRACTIC RETURN FORM

Today's Date: _____

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Sex: _____ Sask Health Card #: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Emergency Contact (Name and Phone #): _____

Please fill out any contact information below that may have changed since your last visit.

Address: _____ City: _____

Prov: _____ Postal Code: _____ Email: _____

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments

_____ Emailed reminders 24 hours prior to appointments

_____ Text reminders 24 hours prior to appointments

_____ Please do not send me any emails/text messages

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients, Chiropractors and other providers, I understand that I must give **3 hours' notice** if I cannot make it to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. _____ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood and agree to the above financial policies. _____ (Initial)**

Patient Signature: _____ **Date:** _____

PLEASE CONTINUE ON OTHER SIDE ⟶

UPDATED CHIEF COMPLAINT AND HEALTH STATUS:

Are your present symptoms or conditions related to/caused by (circle)?

Auto Accident / Work Injury / Sudden Trauma / Repetitive Trauma / Unknown/Gradual

Other - Explain: _____

What is your chief complaint or reason for your appointment? Please describe: _____

_____

_____

When did your condition first begin? Year: _____ Month: _____ Day: _____

Have you had anything like this before? Yes / No When? _____

How often does the problem re-occur? _____

Is the pain (circle)? constant / on & off / or usually lasting - Hours:_____ Days: _____

Lately, has the pain been (circle)? getting better / getting worse / staying the same

Does the pain radiate anywhere?_____

What makes it feel better?_____ Worse?_____

Have you had any blood pressure / blood clotting issues? Yes / N o

Are you or might you be pregnant? Yes / No

Are you currently a smoker? Yes / No Amount? _____ Did you smoke previously? Yes / No

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc): _____

_____

Please list any surgeries, illnesses and hospitalizations you have had: _____

_____

Please list any medications, supplements/herbs you are currently taking: _____

_____

Have you seen another professional for the problem or done any self-care? Describe the type of treatment AND results:

_____

_____

Please list any activities you are unable to perform/ have not performed due to the pain, or for fear of making the pain worse: _____

_____

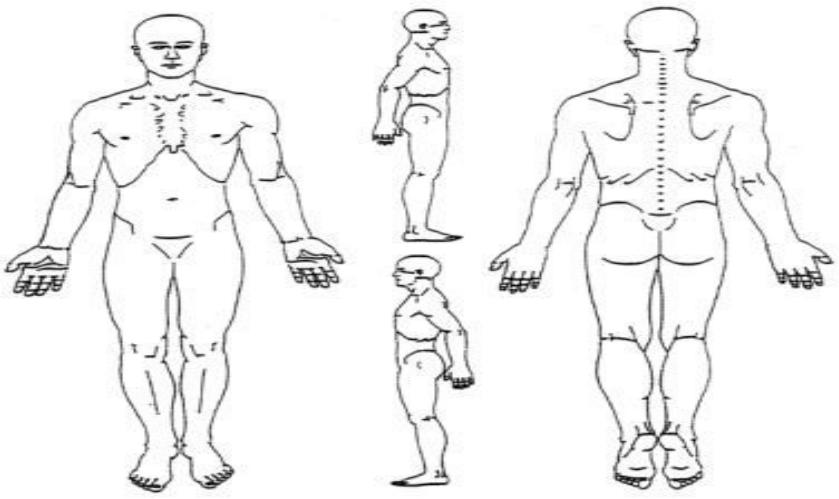
Circle how you would describe the pain:

Sharp/Stabbing Dull/Ache Pins & Needles Numbness Burning

Please circle your level of pain below: (1 = minimal pain; 10 = worst pain imaginable)

Pain Currently	0 1 2 3 4 5 6 7 8 9 10
Pain Typically	0 1 2 3 4 5 6 7 8 9 10
Pain at its Worst	0 1 2 3 4 5 6 7 8 9 10

Please mark the area(s) on the diagram where you are having the problem(s):



Dr Notes (please leave blank):

_____

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