



Noad
Chiropractic
Clinic

NEW PATIENT HEALTH HISTORY FORM

For Your Information :

An accurate health history is important to ensure that it is safe for you to receive chiropractic treatment. If your health status changes in the future, please let us know. Please notify the front desk if you have moved or if any of your personal information changes, as this affects your receipt for insurance submissions. All the information gathered for this treatment is confidential, except as required or allowed by law, or to facilitate assessment or treatment by any Chiropractor here at Noad Chiropractic Clinic. You will be asked to provide written authorization before we release any information from the clinic. All payments are due immediately after your treatment. If you are covered by insurance, and your insurance does not cover any or part of a service you have received, you are liable for this fee. Each therapist or chiropractor at Noad Chiropractic requires 24 hours notice to cancel or reschedule an appointment as we often have a waiting list for acute patients. Failure to do so will result in the full treatment fee being charged (please see our current fee schedule).

If you are covered by insurance:

Please note that you are liable for the cancellation fee and will not be reimbursed by your insurance carrier. Initial _____

I have read and I acknowledge any and all costs with my appointment Initial _____

Did you know that you can book your appointments online 24hrs a day 7 days a week? Ask us how!

Name:		Date: DD/MM/YYYY
Street Address:		City:
Email Address:		Postal Code:
Courtesy reminder calls and emails: Phone Call Reminders Y N Email Reminders Y N		
Home Phone:	Cell Phone:	Work Phone:
Date of Birth: DD/MM/YYYY Age:	Occupation:	Male Female
Emergency Contact:	ER Number:	ER Relationship:

Who referred you to Noad Chiropractic? _____
(we will be rewarding this person with a small token of our appreciation)

Have you ever been injured at work?	
Is this a WSIB case?	If yes, please provide the front desk staff with your information
Is this a Motor Vehicle Accident case?	If yes, please speak with the front desk staff
Current Medication(s) and condition it treats:	
Primary Care Physician (Name/Address/Phone)	
Are you currently receiving treatment from another health care professional? Yes No	
If Yes, for what?	
Have you ever had surgery? Yes No	
If yes, Nature/Date(s):	
Have you ever been hospitalized? Yes No	
If yes, Nature/Date(s):	

Other injuries: Yes No

If yes, Nature/Date(s):

Do you have any internal pins, wires, artificial joints, or special equipment? Yes No

If yes, What?/Where?

Do you smoke? Yes No

If yes, how much:

For how long?

Did you smoke in the past? Yes No

If yes, how much:

For how long?

CURRENT SYMPTOMS:

Please describe your current symptoms: _____

Date of Injury: _____ Date symptoms appeared: _____

Have you ever had the same condition? _____ If yes When? _____

Have you ever had Chiropractic Care? _____ If yes, please describe: _____

Have you had X-rays taken? Where? _____

Height: _____ Weight: _____ Date of last physical exam: _____

Family Health History: Family Members Past and Present Health Conditions (ie.Heart Dis, Diabetes, Cancer)

Please indicate conditions you are currently experiencing with a ☒, or ☐ the conditions you have experienced in the past:

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family history of Respiratory difficulties

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker / similar device
- ☐ Heart disease
- ☐ Family history of cardiovascular difficulties

Infections

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Infectious Skin / Respiratory

Other conditions

- ☐ Loss of sensation
- ☐ Diabetes (Onset: _____)
- ☐ Allergies/Hypersensitivity (_____)

- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis / Family history of
- ☐ Skin conditions _____
- ☐ Osteoporosis / Osteopenia
- ☐ Hemophilia
- ☐ Mental Illness/Nervous Disorder

Head/Neck

- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ History of headaches / migraines

Women

- ☐ Pregnant (DUE: _____)
- ☐ Gynecological conditions, What? _____

Soft Tissue / Joint discomfort and its nature:

- ☐ Neck _____
- ☐ Low Back _____
- ☐ Mid Back _____
- ☐ Upper Back _____
- ☐ Shoulders _____
- ☐ Chest _____
- ☐ Arms _____
- ☐ Legs _____
- ☐ Knees _____
- ☐ TMJ _____
- ☐ Other: _____

Overall, how is your general health? (Circle below)

Excellent / Good / Fair / Poor

NOAD CHIROPRACTIC CLINIC

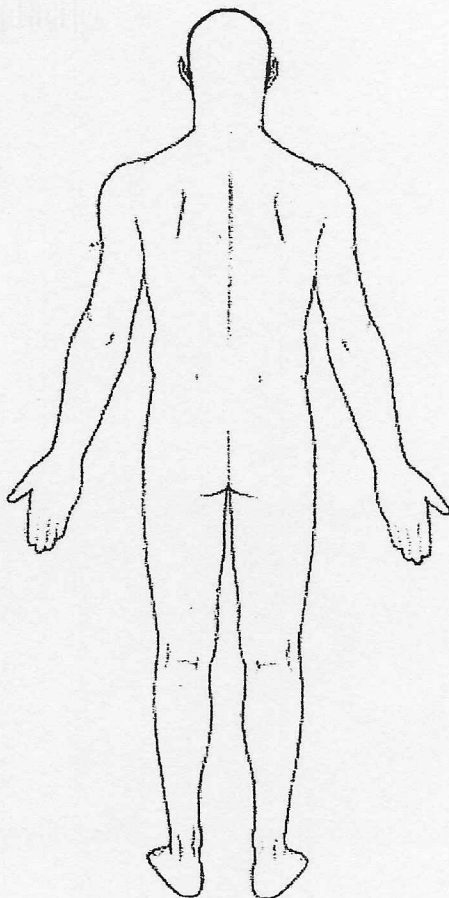
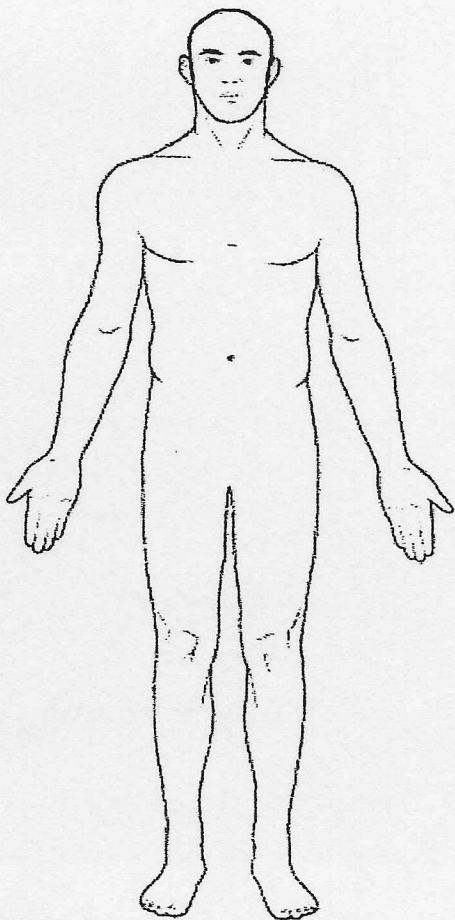


Noad
Chiropractic
Clinic

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing :

A= Ache
B= Burning
N= Numbness

O= Other
P= Pins and Needles
S= Stabbing



EXTENDED INSURANCE INFORMATION:

Do you have Extended Health Insurance? _____

If yes, please fill out and we can bill for you

Name of Insurer: _____ Policy #- _____ Group #- _____

If auto accident please provide: Claim number: _____

I have read the above information and have stated all my previous medical conditions. I take it upon myself to update the Chiropractor regarding changes to my condition. I understand that all chiropractic treatments will be discussed and planned with the Chiropractor, and will require my informed consent.

Furthermore, I authorize that the Chiropractors and/or Massage Therapist providing care at Noad Chiropractic Clinic have full access to my client file.

Patient Signature: _____

Date: _____