Welcome to McCallum Wellness Chiropractic!

New Patient Health History

Name: _____ Age:_____ Date:_____

Address:_____ City:_____ Prov:_____ P.C:_____

Home Phone: ( ) _____ Work: ( )_____ Cell: ( )_____

Male: _____ Female:_____ Date of Birth: _____#of Children_____

Circle One: Single Married Widowed Divorced Separated Other - Spouse's Name:_____

Occupation: _____Business/Employer:_____

Email Address: _____

Have you seen a Chiropractor Before? Yes___ No___ If yes, when?_____

Whom may we thank for referring you to the office?_____

Who is responsible for your bill? You and_____ Spouse_____ WSIB_____ Auto Insurance_____

How will you be taking care of your account? Credit___ Cash_____ Cheque_____ Interac_____ Other _____

Visa or MasterCard Number:_____Expiry:_____

Your Health Summary

Current Complaint(s):_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐Headaches	☐Pins and Needles in legs	☐Fainting	☐Neck Pain
☐Pins and Needles in arms	☐Loss of Smell	☐Back Pain	☐Loss of balance
☐Dizziness	☐Sinus trouble	☐Difficulty hearing	☐Nervousness
☐Numbness in arms/fingers	☐Irregular heart beat	☐Ringing in ears	☐Stomach upset
☐Fatigue	☐Numbness in legs/toes	☐Ear aches	☐Heartburn
☐Sleeping problems	☐Depression/confusion	☐Loss of taste	☐Ulcers
☐Cold sweats	☐Neck stiff	☐Irritability	☐Tension/Stress
☐Mood swings	☐Constipation	☐Cold hands/feet	☐Hot flashes
☐Weight trouble	☐Diarrhea	☐Fever	☐Chest pain
☐Sore throat	☐Lights bothers eyes	☐Problem urinating	☐Shortness of Breath
☐Menstrual Pain	☐Menstrual Irregularity	☐Bladder frequency	☐Diabetes
☐Blood Pressure Problems	☐Sexual Dysfunction	☐Epilepsy	☐Cancer
☐Mental Disorder	☐Blurred vision	☐Allergies	☐Water Retention
☐Skin Problems	☐Heart Disease	☐Thyroid	☐Asthma

List any medications you are taking:_____

_____

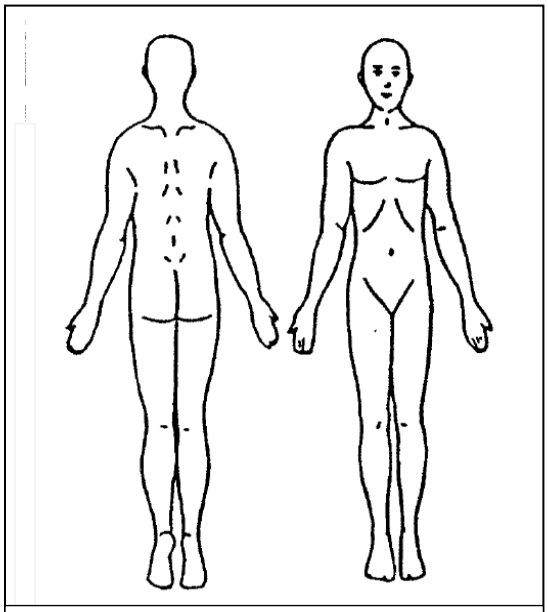
Family Health History:(Many health problems are the result of hereditary spinal weaknesses. Thus, information about you family

_____

members will give us a better picture of your total health. Please list any member of your family who has any kind of health problem.)

Does any member of your family suffer from the same condition? Yes☐ No☐

Have your children ever had a spinal check-up? Yes☐ No☐



Please outline on the diagram the area of your discomfort and any radiation of pain

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

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 name below.

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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

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 and for any future conditions(s) for which I seek treatment.

Patient/Lawful Representative's Signature_____ Date_____

Witness Attending D.C./Assistant's Signature_____ Date_____