SOUTH POINT CHIROPRACTIC

Unit 205 – 2828 152nd Street
Surrey, B.C. V4P 1G6
604-535-2289

PATIENT INTRODUCTION FORM **File # _____**

Last Name: _____ First name: _____

I prefer to be called: _____ Birthdate: _____ M / F

Marital Status:_____ Spouse name:_____

Address: _____ Cell Phone:_____

City: _____ Postal Code: _____ Home Phone: _____

Your occupation: _____ Email: _____

Women only: Do you have reason to believe that you may be pregnant? Yes____ No _____

Referred to this office by? (*circle one*)
Online Doctor Advised Family/ Friend: _____ Other: _____

Are you claiming under W.C.B.? No: _____ Yes: _____ Claim # _____

Are you claiming under I.C.B.C.? No: _____ Yes:_____ Claim # _____

INJURY/CONCERN

1. Please briefly describe your complaint:
   _____
   _____
2. How did it begin? _____
3. How long have you had it? _____
4. Please describe if the pain is dull/sharp/radiating etc. _____
   _____

Turn Over ⇨

INJURY/CONCERN

5. What other types of treatment have you done for this condition? (*circle all that apply*)

MD Massage Physiotherapy Chiropractic None

6. Were any of the other treatments that you received helpful? Yes ___ No ___

Explain:_____

7. Rate the severity of pain (1= mild to 10 = severe): 1 2 3 4 5 6 7 8 9 10
(*Circle one*)

HEALTH HISTORY

1. Do you have any difficulty with the following? Please check all that apply below:

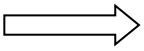
O Headaches	O Sciatic	O Loss of balance
O Migraines	O Knee pain	O Poor posture
O Head pains	O Low back pain	O Sinus troubles
O Neck pain	O Mid back pain	O Menstrual cramps
O Shoulder blade pain	O Pain in legs	O High blood pressure
O Arm pain	O Tingling in legs	O Nervousness
O Tingling in arms	O Fatigue	O Indigestion
O Hip Pain	O Irritability	O Cancer
O Shoulder Pain	O Diabetes	O Vertigo

2. Have you ever had any major falls, car accidents or injuries? O Yes O No
(Please explain/give year)_____
_____

3. Have you had any surgery? O Yes O No If yes, please describe the type of surgery(s)& year(s):
_____
_____

4. What medications are you currently taking?_____

5. Is there anything else you feel the Doctor should know?
_____
_____



SOUTH POINT CHIROPRACTIC

Patient Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including X-rays if necessary, on me by the Doctor(s) of Chiropractic affiliated with me. I have had an opportunity to discuss with the doctor(s) of chiropractic, adjustments and other procedures. Although I am expected to get great benefit from chiropractic care, I understand that the results are not guaranteed. I further understand and am informed that as in all health care, with certain chiropractic techniques, there are some very slight risks to treatment, including, but not limited to, muscle strains, and sprains, disc injuries and rib fractures. The possibility of an associated stroke with an upper cervical adjustment is extremely remote and un-established.

I do not expect the doctor to be able to anticipate all the risks and complications. I rely on the doctor's exercise of judgment which chiropractic procedure, based upon the facts known, is in my best interest. I have read this consent. 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 current and future chiropractic care for which I seek treatment.

I understand that I am responsible for payment of all services and that they are to be paid in full at time service is rendered, unless prior arrangements have been made.

Please read this consent form & sign it once you have discussed it with the doctor.

Patient's Signature:_____ Date: _____

Guardian's Signature: _____ Date: _____

Witness Signature: _____ Date:_____

(Doctor to Witness)