# Liberty Chiropractic New Patient Form

## PATIENT INFORMATION

Date _____

Provincial health card number _____

Patient name _____

Address _____

Postal Code _____

City _____

Province _____

Email _____

Sex _____

Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Common Law

Children (# of) ☐ Girls ☐ Boys

Occupation _____

Employer/School _____

Whom may we thank for referring you?

_____

### Contact Numbers

Home Phone _____

Cell Phone _____

Preferred Phone Number _____

IN CASE OF EMERGENCY

Name _____

Relationship _____ Phone number _____

## INSURANCE

Insurance Company _____

Who is the account holder? _____

Policy # _____

Member ID _____

Are you covered by additional insurance? ☐ Yes ☐ No

Subscriber's name _____

Birth date _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with

_____

(Name of insurance company(ies)

And assign directly to **Dr. Timothy Sharp at Liberty Chiropractic.** I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Sharp may use my health care information and may disclose such information to the above named insurance company(ies)and their agents for purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of patient, parent, guardian or personal representative

_____

Please print Signature of patient, parent, guardian or personal representative

_____ _____

Date Relationship to Patient

## Reason for Visit

☐ Personal health reason ☐ Motor vehicle accident case

☐ Work related Injury? (If so, we are not a Worker's Compensation Board Clinic (WCB), therefore any fees incurred during your visit are your responsibility

Present Symptoms (Please list) _____

_____

_____

## Medication/Vitamins/Supplements/Homeopathies

Please list _____

_____

_____

_____

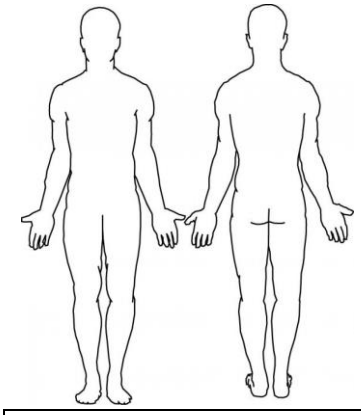
_____

# Medical History

Below are lists of Diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**Please circle all that apply**

| | | | |
|---|---|---|---|
| Pneumonia | Mumps | Influenza | **Intake** |
| Rheumatic Fever | Pleurisy | Eczema | Cigarettes |
| Polio | Chicken Pox | Arthritis | Coffee |
| Tuberculosis | Diabetes | Epilepsy | Tea |
| Whooping Cough | Cancer | Mental disorders | Alcohol |
| Anemia | Heart Disease | Lumbago | Marijuana |
| Measles | Thyroid | | |



Please indicate areas of discomfort or problems in the Diagram above

## Check any of the following you have had in the past 6 months

### Musculo-skeletal

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Pain
- ☐ Walking problems
- ☐ Difficult chewing/clicking jaw
- ☐ Joint pain/Stiffness

### General

- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Fever
- ☐ Allergies
- ☐ Headaches
- ☐ General stiffness

### Gastro-Intestinal

- ☐ Poor/Excessive appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomittng
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/bloating after meals
- ☐ Heart burn
- ☐ Black/bloody stool

### Cardiovascular/Respiratory

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood pressure issues
- ☐ Irregular heart beat
- ☐ Heart problems
- ☐ Varicose veins
- ☐ Stroke
- ☐ Ankle swelling
- ☐ Lung Problems/congestion

### Nervous System

- ☐ Nervous
- ☐ Stress
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold tingling extremities

### Eyes/Ears/Nose/Throat

- ☐ Vision Problems
- ☐ Dental
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

### Urinary

- ☐ Bladder trouble
- ☐ Painful/excessive urniation
- ☐ Discoloured urine

### Family History

Does a member of your family have the same or

Similair problem to you? Yes ☐ No ☐

If so, who? _____

## Women Only

Menstrual irregularity  Vaginal pain/ Infection  When was your last period? _____

Menstrual Cramps  Breast Pain/Lumps  Are you pregnant? ☐ Yes ☐ No

## Men Only

☐ Prostate/sexual dysfunction