



Patient Information Form & Clinical Record
Please Print

Date _____

Name _____
(Last) (First) (Middle)

Care Card # _____ Date of Birth _____ Age _____
(Mm/dd/yy)

Mailing address: _____ City _____ Postal Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Occupation _____

Email Address (for appointment reminders only): _____

Employer _____ Spouse's Name _____

of Children _____ Who referred you to this office? _____

Have you received Chiropractic care before? _____ By Whom? _____ Last Visit _____

Are you claiming under? WCB ICBC Claim # _____

Have you ever had any major falls, accidents or sporting injuries? Yes No

Date(s) of injuries: _____

Give details:

Any care given?

What brings you to our office today? _____

Has this condition caused you to miss work or caused interference with your daily activities?

Yes

No

