Chiropractic
Acupuncture
Massage Therapy
Foot Orthotics
Naturopathic Medicine

KING WEST CHIROPRACTIC HEALTH CENTRE
145 King St. West, Concourse Level M5H 1J8 Tel: 416-815-9595 Fax: 416-815-9009
Email: kwc@bellnet.ca www.kingwestchiropractic.com

Patient Entrance Form for Drs. Chan, Lyons & Bowness

Name ____ **Date** _______________
Address ____
City __________________ **Province** ______________ **Postal Code**_______________

How did you hear about our office? Check all that apply:
Friend _____ **Friend's Name** ______________________________
Internet _____ **Google?** ________ **Yellowpages.ca?** _______ **Other** ____________
Phone Book _____ **Passing by** _____

Date of Birth **D/M/Y** __________________ **Age** _______________ **Male or Female**
Telephone: **Home** __________________ **Work** ______________ **ext.** __________
Cell ____________________
Email ____

Marital Status: S M D W Sep.
Spouse's Name _______________________________
No. of Children ______________________________
Closest Relative _______________________________ **Contact No.** ___________________
Occupation ____
Employer ____
Address ____

Claim will be made against: **Motor Vehicle Accident Insurance** **yes/no**
Work related injury/accident **yes/no**
Health Insurance Benefits **yes/no**
(please note that we do not direct bill insurance for you)

Medical Doctor's Name ________________________ **Clinic** __________________________
Address ____________________________________ **Phone** __________________________
Date of last appointment _______________________ **Date of last physical** _______________

Health History: Name ______________________________ Date ______________

Have you ever had…..?

Measles___ Chicken Pox___ Whooping Cough___ Scarlet Fever___ Diphtheria___
Mumps___ Rheumatic Fever___ Typhoid Fever___ Chronic illness___ Tubes in Ears___
Aneurysm___ Osteoporosis___ Diabetes___ Arthritis___ Heart condition___
Epilepsy___ Stroke___ Hepatitis___ Anxiety___ Breathing Condition___
Polio___ Pneumonia___ Pleurisy___ Asthma___ Sinus Infections___
Psoriasis___ HIV/AIDS___ VD___ Fatigue______________________________
Allergies____
Cancer____

Have you had previous Chiropractic care?
Name______________________________ City______________________________
Name______________________________ City______________________________
Results____
____

Have you ever had X-rays taken? Yes/No
Who took them ______________________
Results/findings____

What medications do you take and why: (include birth control)
____
____
____
Are you a smoker? Yes/No Number of cigarettes per week___________
Do you exercise regularly? If yes, what do you do and for how long______________________
____
____

Reason for consulting this office ______________________________________
____
____
Expectations____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

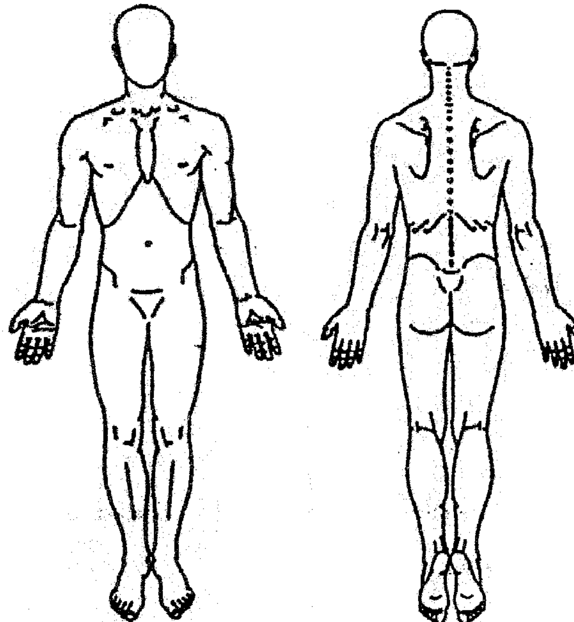
Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning XXXXX
XXXXX
XXXXX

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



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Dear Patient: *Welcome to King West Chiropractic Health Centre!*
Please take a few moments to read over our office policy. We will be happy to answer any questions you may have regarding this policy or procedures employed in the clinic.

CLINIC OFFICE POLICY

Clinic Hours: Monday to Friday – 7: 45 am to 6:30 pm

Fee Schedule

Chiropractic:	**Fee**	**Packages:**
Initial Examination	75.00	
Subsequent Visit	40.00	12 Visits @ 36.00 x 12 = 432.00
		24 Visits @ 34.50 x 24 = 828.00
Student/Senior (Initial Exam.)	55.00	________
Subsequent Visit	34.00	________

Acupuncture:	**Fee**	**Packages:**
Initial Examination	75.00	
Subsequent Visit	45.00	12 Visits @ 41.00 x 12 = 492.00
Student/Senior	37.00	
Ultrasound Treatment	15.00	________

Massage Therapy (GST included):	
30min treatment	45.00
45min treatment	65.00
60min treatment	85.00
75min treatment	105.00
90min treatment	120.00

** **All prices subject to change**.

Missed Appointments

At least 24 hours notice is required when cancelling or rescheduling any appointments. Patients are responsible for the full fee of any missed appointment without 24 hour notice.

Insurance

Many benefit plans cover some or all of our services to some extent. While our office does not deal directly with insurance companies, we do issue official receipts which may be submitted for reimbursement.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your account and clinic updates/promotions.

Patient Signature:______________________________ ***Date***:____________