

**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 \_\_\_\_\_ Activator.com \_\_\_\_\_ Other \_\_\_\_\_

Yellowpages.ca \_\_\_\_\_ 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 \_\_\_\_\_

Your Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Closest Relative \_\_\_\_\_ Contact No. \_\_\_\_\_

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 \_\_\_\_\_

Smoking \_\_\_ cig/day

Coffee \_\_\_ cups/day

Water \_\_\_ glasses/day

Alcohol \_\_\_ oz/day

Meals \_\_\_ /day

Medications and/or Supplements: \_\_\_\_\_

Exercise: \_\_\_ # days/week

What type of exercise? \_\_\_\_\_

Family History (please circle): diabetes heart disease cancer low back pain neck pain headaches

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

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• • • • •
• • • • •
• • • • •

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Pins & Needles

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0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

```

Burning

```

X X X X X
X X X X X
X X X X X

```

Aching

```

* * * * *
* * * * *
* * * * *

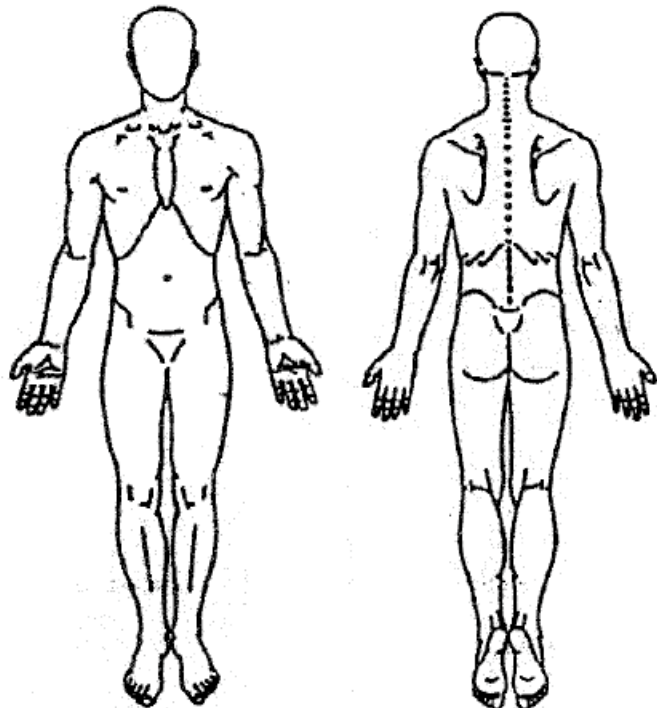
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Stabbing

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/ / / / /
/ / / / /
/ / / / /

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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.

## **OFFICE POLICY**

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

### **Fee Schedule**

<b><u>Chiropractic:</u></b>	<b>Fee</b>
Initial Examination	75.00
Subsequent Visit	41.00

<b><u>Acupuncture:</u></b>	<b>Fee</b>
Initial Examination	75.00
Subsequent Visit	46.00

<b>Ultrasound Treatment</b>	15.00
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<b><u>Massage Therapy (HST included):</u></b>	
30 min treatment	49.00
45 min treatment	70.00
60 min treatment	92.00
75 min treatment	113.00
90 min treatment	130.00

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

### **Massage Therapy Missed Appointment Policy**

**24 hours notice is required when cancelling or rescheduling massage appointments. If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.**

### **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:** \_\_\_\_\_