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

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Date of Birth *dd/mm/yyyy* _____ Age _____ Male / Female

Phone *Home* _____ *Work* _____ *ext* _____ *Cell* _____

Email _____

Marital Status: *S M D W Sep.* Spouse's Name _____ No. of Children _____

Closest Relative _____ Contact No._____

How did you hear about our clinic? *Check all that apply:*

☐ Friend (*Name)*_____ ☐ Colleague (*Name)* _____

☐ Internet *(Google)* ☐ Internet *(activator.com)* ☐ Passing by ☐ Phone Book ☐ Other

Your 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 _____
Results _____

Have you ever had X-rays taken? *Yes / No* _____
Results / findings: _____

☐ Smoking _____ cig/day ☐ Coffee _____ cups/day ☐ Water _____ glasses/day
☐ Alcohol _____ oz/week ☐ Meals _____ /day
☐ Exercise _____ # days/week What type of exercise _____

Medications and/or Supplements: _____

Family History *(please circle):*
Diabetes Heart Disease Cancer Low Back Pain Neck Pain Headaches Stroke

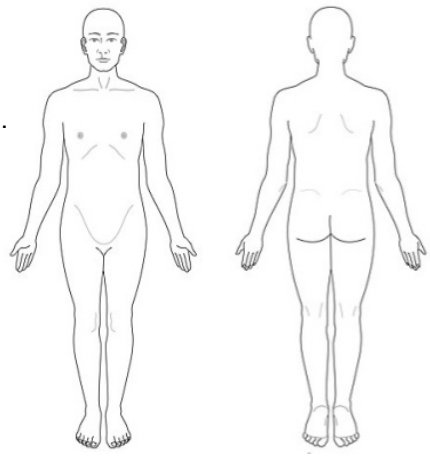
Have you been in an auto accident in the last 20 years? *Yes / No*
Have you had any slips/falls/concussions in your lifetime? *Yes / No*

Reason for consulting this office: _____
_____

Expectations: _____
_____

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 of radiation. Include all affected areas.

Numbness ●●● Pins & Needles OOO
Burning X X X Aching ★★★
Stabbing +++



Drs. Chan and Lyons

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OFFICE POLICY

Welcome to King West Chiropractic Health Centre.

Clinic Hours

Chiropractic:	Monday to Friday 8:00 am to 6:00 pm
Massage Therapy:	Monday to Friday 9:00 am to 7:00 pm
Osteopathic:	Monday/Wednesday/Friday 10:00 am to 6:00pm

Insurance

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

Scent-Free Policy

KWC is a scent-free clinic – please refrain from wearing perfume or cologne.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when
cancelling or rescheduling
massage and osteopathic appointments.

If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.

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.

☐ Please check this box if you consent to receiving our clinic newsletter (sent by email once per month).

Email _____

Patient Signature _____ **Date** _____