**PARAMOUNT FAMILY CHIROPRACTIC**

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# NEW PATIENT APPLICATION FORM

**(Please Print)**

***Our policy requires payment in full for all services rendered at the time of visit.***

Please Sign: ________________________________________

Reason for today's visit:
❒ Wellness Visit ❒ Emergency ❒ New Injury ❒ Old Injury ❒Chronic Pain

*Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.*

*How did You hear about our office ?* ___________________________________

Name: ________________________________________________________________

Address:__________________________________ City: _________________________

Postal Code:____________ Phone: (H) ________________ (W) ___________________

Cell ________________ Email _______________________________________________

Age: __________ Date of Birth: (DD) ________ (MM) ________ (YY) ________

Occupation:______________________ Where: ___________________________________

Spouse Name:____________________________ Age: __________________

Children: ❒ Yes ❒ No

Name: _________________ Age: ______ Name: _________________ Age: _____

Name: _________________ Age: ______ Name: _________________ Age: _____

Health Card #__________________________________ Expiry Date: ______________

Family Physician _______________________________ Phone #: ________________

Last Visit: ___________________ Reason: _______________________________

I give my consent to PFC to contact my GP to discuss or update my case? ❒ Yes ❒ No
Have you had any previous chiropractic care? Y/N
If yes, what was the chiropractor's name? ____________________________________

and when was your last visit? ____________________________________

Have you had Back or Neck X-rays taken? Y/N
If yes, where and when? ____________________________________________

Is this a Personal Injury case: ❒ Yes ❒ No
Is this a Motor Vehicle case: ❒ Yes ❒ No
Is this a Workers' Compensation case: ❒ Yes ❒ No

Who will be responsible to pay for your account? ______________________________

What is your major complaint or crisis? _________________________________________

_____________________________________________________________________________

How did this problem start? ___________________________________________________

How long have you had this condition? __________________________________________

What activities aggravate your condition/pain? ___________________________________

What activities lessen your condition/pain? ______________________________________

Is condition worse during certain times of the day? ________________________________

How is this condition interfering with Your work? Sleep? Daily Routine?

___________________________________________________________________________

___________________________________________________________________________

Any home remedies? _______________________________________________________

Have you had any treatment for this specific complaint prior to coming to this office?

❒ Yes _____________________________________ ❒ No

Other symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ringing
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Nausea

Name:________________________________________ File #: __________ Date: ________________

Family History:

|  | Heart Disease | Arthritis | Cancer | Diabetes | Other |
|---|---|---|---|---|---|
| Father's Side | ❐ | ❐ | ❐ | ❐ | ________________________ |
| Mother's Side | ❐ | ❐ | ❐ | ❐ | ________________________ |

**Your oldest grandparent lived to the age of _________.** ❐ Still living ❐ Deceased

What medications do You take? We can photocopy Your list for You.

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Do you take supplements or vitamins? ❐ Yes ❐ No

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

List all surgical operations, injuries, fractures and scars.

______________________________________________________________________________

______________________________________________________________________________

Have you been prescribed or do you wear, Foot Orthotics, Heel Lifts? Y/N

What do you like to do in your spare time, hobbies or activities?

______________________________________________________________________________

______________________________________________________________________________

WOMEN:
Are you taking Birth Control? Yes❐ No ❐
Are you nursing? Yes❐ No ❐
Are you pregnant? Yes❐ No ❐

If so, how many weeks? ________________________
If not, when was the onset of your last menstrual cycle?______________________

Name:________________________________________ File #: __________ Date: ________________

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires *payment in full for all services rendered at the time of visit*.
- I authorize the staff to perform any necessary services/exam procedures needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand it is my responsibility to inform this office of any changes to my health and any other information I have provided.
- I consent to a physical examination and chiropractic evaluation to be performed at my initial visit today.

Upon the completion of your first visit, you will be scheduled for and receive a Chiropractic Report of Findings to discuss the Lifestyle Care Continuum and how chiropractic can get you feeling better quickly and to help you and your family to be as healthy as possible. Please review the plan explanations and types of care available prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

*As a result of my chiropractic care, I would like to (Please check all that apply)*

- ❐ Feel better quickly
- ❐ Have a healthier spine and nervous system
- ❐ Live a healthier lifestyle

Is there anything you would like to add or ask at this time?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Signature ________________________________ Date _____/_____/________

❐ Adult Patient ❐ Parent or Guardian ❐ Spouse

Name:______________________________ File #: ________ Date: ____________

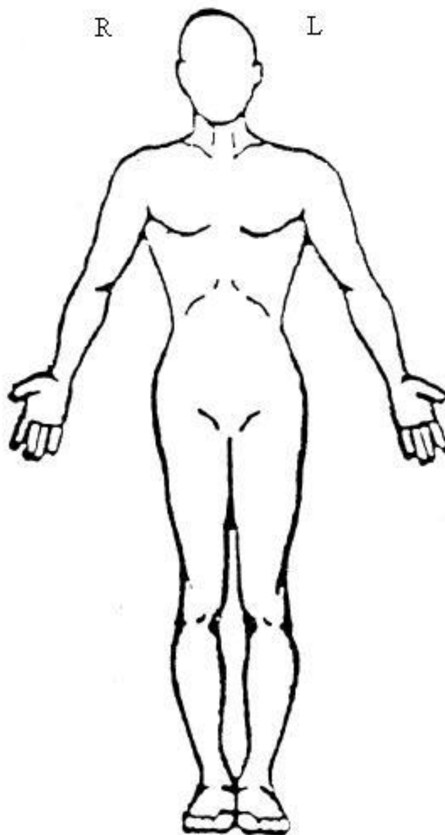
# Pain Scale

Rate your pain with the following scale:

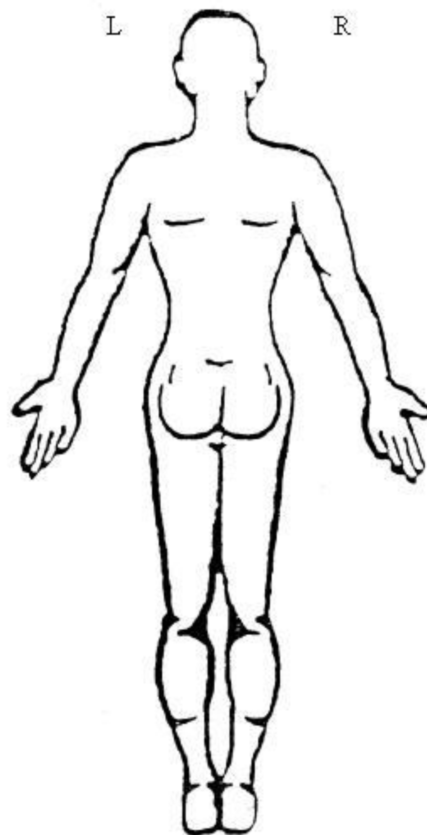
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

# Pain Diagram

Using the symbols provided please indicate all areas of your body where you are experiencing pain:




Front




Back

**Diagram Key:**

A=Ache

S=Stabbing

B=Burning

P=Pins & Needles

N=Numbing

T=Stiff & Tight