VIP Health Care Clinic
2610 Weston Road, Unit #2, North York, ON, M9N 2B1
Phone: (416) 792-2610 Fax: (416) 792-2628
Website: www.VIPhealth.ca

NEW PATIENT FORM

Date of Visit (D/M/Y) ____/____/_____ Sex: M ☐ F ☐ Marital Status S ☐ M ☐ D ☐ W ☐

Name _____ **Date of Birth (D/M/Y)** _____/_____/_____ Age _____

Last *Middle* *First*

Address _____ City _____ Postal Code _____

Phone (Home) _____ Phone (Cell) _____ Email _____

Occupation _____ Employer _____ Phone (Work) _____

Who referred you to the clinic? Family Physician ☐ Family/Friend ☐ Self ☐ Other ☐ _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: Name _____ Relationship to Patient _____

Phone (Home) _____ Phone (Cell) _____ (Work) _____

Family Physician: _____ Phone: _____

REASON FOR TODAY'S APPOINTMENT

Major Complaint(s)? 1) _____ 2) _____ 3) _____

How long have you had this complaint? _____

Since the onset of my symptoms (pain), my condition has? Improved ☐ Gotten Worse ☐ Stayed the Same ☐

Have you been treated recently for this condition? Yes ☐ No ☐ If yes, by whom? _____

Is your injury due to? Car Accident ☐ Work Injury ☐ Other ☐ _____

HEALTH INSURANCE INFORMATION

Do you have extended health care benefits? Y ☐ N ☐ Do you have coverage for chiropractic care? Y ☐ N ☐

EHC/Insurance Company _____ Phone: _____

Policy Number: _____ Member ID Number: _____ Division Number _____

Policy Holder's Name: _____ Relationship to Patient? Self ☐ Spouse ☐ Mother ☐ Father ☐

WSIB Information	Auto Accident Information
Claim Number: _____	Policy Number: _____
Adjudicator: _____ Phone: _____	Insurance Co. _____ Phone: _____

PERSONAL HEALTH HISTORY

Current Medications? _____

Past Hospitalizations/Surgeries? _____

Past Car Accidents/Trauma? _____

Do you smoke? Yes ☐ No ☐ If yes, how many packs/day? _____

Do you drink alcohol? Yes ☐ No ☐ If yes, how much/week? _____

Please check the following conditions that apply to you. Add any comments to clarify condition.

☐ Feet Pain	☐ Headache/Migraine	☐ Muscle Cramps/Spasm	☐ Scoliosis
☐ Cancer	☐ Heart Disease	☐ Neck Pain/Stiffness	☐ Sciatica
☐ Chronic Pain	☐ Hypertension	☐ Numbness/Tingling	☐ Calf/Leg Pain
☐ Diabetes	☐ Joint Pain/Stiffness	☐ Osteoporosis	☐ Stroke/Aneurysm
☐ Fatigue/Weakness	☐ Kidney Problems	☐ Poor Circulation/Bruising	☐ Other: _____
☐ Fracture	☐ Low Back Pain	☐ Rheumatoid Arthritis	_____

LIFESTYLE HISTORY

What is your level of exercise? Daily ☐ 2-3 Times/Week ☐ Once/Week ☐ Once/Month ☐ Rarely ☐

What activity do you do most on a daily basis? Sit ☐ Walk ☐ Stand ☐ Lift ☐ Other? _____

Do you take any vitamins/mineral supplementation? _____

How much water do you consume on a daily basis? _____

Hobbies/Sports/Recreation? _____

FAMILY HEALTH HISTORY

Please check any of the following if anyone in your immediate family has or has had any of the following conditions (mother, father, siblings, grandmother, grandfather). Add any comments to clarify condition.

☐ Cancer	_____	☐ Rheumatoid Arthritis	_____
☐ Heart Disease	_____	☐ High Cholesterol	_____
☐ Stroke/ Aneurysm	_____	☐ Hypertension	_____
☐ Diabetes	_____	☐ Other	_____

AUTHORIZATION OF CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and/or joints of the extremities as well as manual therapies to the associated soft tissue structures, as he or she deems appropriate I clearly understand and agree that I am responsible for all bills incurred at the time of treatment rendered. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable.

_____ _____

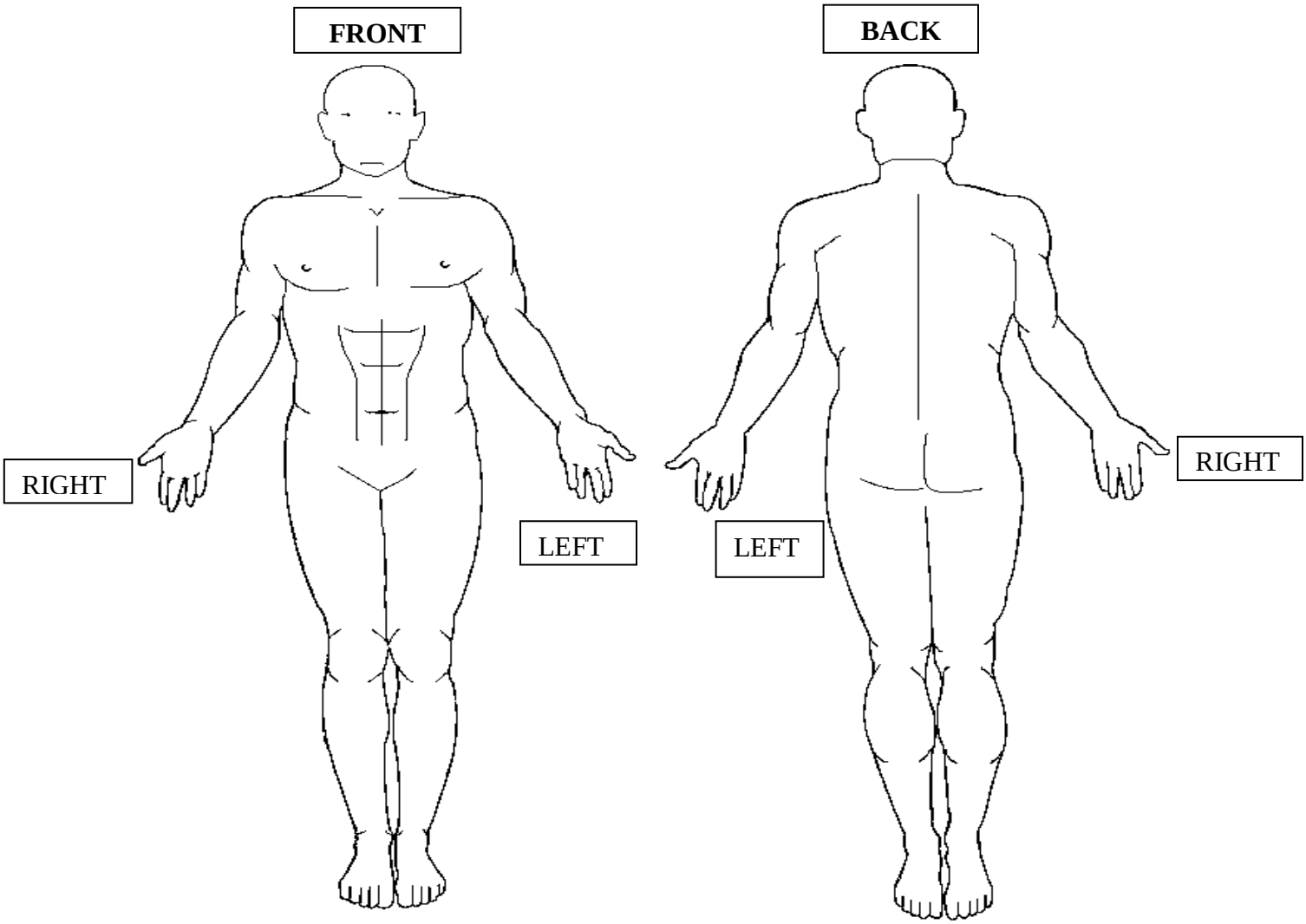
Patient Signature Date

PAIN DIAGRAM

Patient Name: _____ Date: _____

Instructions:
Below is a diagram of a body, front and back. Please use the symbols below to mark on the diagram where you feel your symptoms. After completing this diagram, please answer the questions below.

xxx	Dull Achy	= = =	Numbness	^^^	Pins/Needles
/ / /	Sharp/Stabbing	000	Stiffness	□□□	Other _____



On a scale of 0-10 (10 being the worst), mark with a single line (/) your current level of pain

0 (NO PAIN) ——————————————————— **10(WORSE)**

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