Adult Consultation History

Your Name: ____Phone:_________________________

Address: ____

City: ___________________________ Postal Code: _______________ Birth Date: _____________________

(Day/Month/Year)

Email Address: ____

Your Occupation: _________________________________ Employer: ________________________________

Employer Address: ____Phone: _______________________

(If can be reached there)

Spouse's Name: ____

Medical Doctor: ____

How did you hear about our clinic? ____

Your Main Complaint: ____

Any other Complaints: ____

How long have your suffered with this problem? ____

What have you tried to do to get rid of this problem that DID NOT work? ________________________

____

How does this problem interfere with the following areas of your life?

WORK: ____

FAMILY: ____

HOBBIES: ____

LIFE: ____

What do you do that makes this problem worse? ____

What gives you some temporary relief? ____

What is the pattern of this problem? Constant ____ Intermittent ____ Occasional ____ Cyclic ____

How did it start? ____

Is this a Worker's Safety & Insurance Board (WSIB) case? YES/NO If yes, Date of accident: _______________

Have you been involved in a motor vehicle accident? YES/NO If yes, Date of accident: ____________________

Any difficulties from this? ____

Is there any other information you would like us to know? ____

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On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

I know that the office has a Privacy Code, and I can ask to see the code at any time. I agree that Fairway Chiropractic Centre can collect, use and disclose personal information about me as set out in the office's privacy policies.

Signature: _______________________________________ Date: ___________________________________

Thank you!

Fairway Chiropractic Centre

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