

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of birth: (M/D/Y) \_\_\_\_\_

Civil status: Married  Living common-law  Single  Divorced  Widowed  Other  Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Office phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

What is the best way to reach you? Home phone  Cell phone  Office phone  E-mail

Do you authorize the clinic to contact you by e-mail? Yes  No

Do you authorize the clinic to leave a message at the specified number to confirm an appointment? Yes  No

Occupation: \_\_\_\_\_ Are you currently on leave from work? Yes  No

Do you have any children? Yes  No  If so, how many? \_\_\_\_\_

Referred by: Other professional  Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Spouse  Friend  Parent  Co-worker  Name: \_\_\_\_\_

Advertisement  Website  Yellow Pages  Facebook  Google  Other : \_\_\_\_\_

Name of your family physician: \_\_\_\_\_

Last appointment: \_\_\_\_\_ Date of last medical examination: \_\_\_\_\_

Have you ever consulted a chiropractor? Yes  No

Who? \_\_\_\_\_ When? \_\_\_\_\_

Are you consulting for a problem related to an occupational accident (CNESST)? Yes  No

Are you consulting for a problem related to a car accident (SAAQ)? Yes  No

Name of representative: \_\_\_\_\_ File number: \_\_\_\_\_

Is your treatment covered by a Veterans Program or IVAC? Yes  No

Do you agree to have us reply to requests made by your insurer, Veterans Affairs Canada, IVAC, the CNESST or the SAAQ regarding your treatment dates and the amounts paid for those treatments? Yes  No

Person to contact in case of emergency:

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Relationship: \_\_\_\_\_

I hereby authorize the chiropractor to conduct the examinations that he or she deems necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally do not last long, it is important to mention them to the chiropractor at your next appointment.

Patient's signature or signature of person responsible: \_\_\_\_\_

Date: \_\_\_\_\_