



METROTOWN  
FAMILY  
CHIROPRACTIC

CHIROPRACTIC INTAKE FORM			
Last Name		First Name	Email Address
Is this your preferred name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:    Gender Pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They
Home address:		Phone Number and Carrier (    )	<input type="checkbox"/> Telus <input type="checkbox"/> Rogers <input type="checkbox"/> Bell <input type="checkbox"/> Other: _____
City:	Province:	Postal Code:	Personal Health Number (PHN):
Occupation:	Employer:	Work Phone Number (    )	
Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Google <input type="checkbox"/> Yelp <input type="checkbox"/> Friend/Family Member: _____ <input type="checkbox"/> Close to home/work <input type="checkbox"/> Other: _____			
Family Physician Name: _____		Family Physician's Clinic Name: _____ Phone Number: _____	
EXTENDED HEALTH INFORMATION FOR DIRECT BILLING			
Extended Health Insurance Provider: <input type="checkbox"/> Great West Life <input type="checkbox"/> Sunlife <input type="checkbox"/> Blue Cross <input type="checkbox"/> Manulife <input type="checkbox"/> Other: _____			
Extended Health Card Number: _____		Policy Number: _____	
Name of the Primary Card Holder: _____		Birthday of Primary Card Holder (MM.DD.YR): _____	
Primary reason for visit (Please Describe):   			
Is today's visit related to a motor vehicle accident or workplace injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please list the following:  Date of the Accident (MM.DD.YR): _____  Claim Number: _____  Adjuster Name: _____  Adjuster Phone Number: _____			
EMERGENCY CONTACT			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		(    )	(    )

## **MISSED APPOINTMENT POLICY/MSP ASSIGNMENT**

I understand that I am financially responsible for medical services provided to me and missed appointments. If I am unable to keep an appointment, I must provide the clinic **at least 24 hours' notice** to cancel otherwise the full amount of the treatment will be invoiced. There are two ways to modify/cancel an existing appointment:

1. Visiting our website and utilize our online booking platform [www.metrotownchiropractic.com](http://www.metrotownchiropractic.com)
2. Email [info@metrotownwellness.com](mailto:info@metrotownwellness.com) or Call 604-430-1525

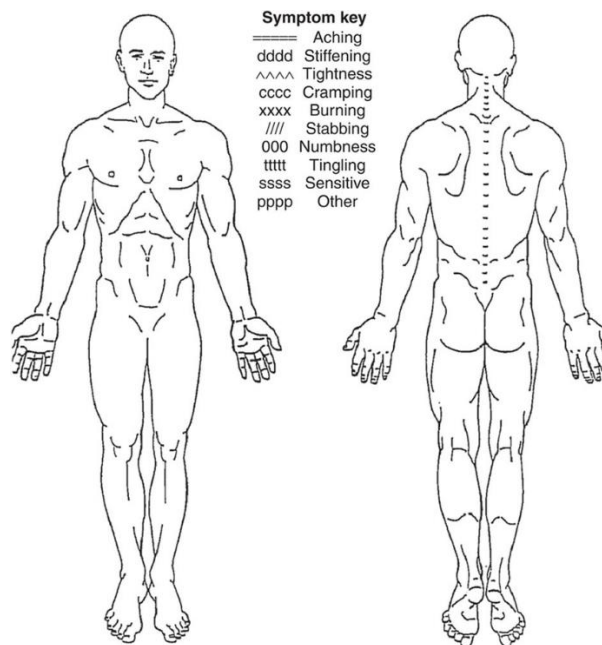
I authorize Medical Services Plan to pay Metrotown Family Chiropractic directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me at this clinic. I make this assignment in full knowledge of the amount that I will personally be responsible for and the amount that is reimbursable by the Medical Services Plan which will be directed to Metrotown Family Chiropractic to be applied against any outstanding monies I owe for services provided.

By Signing below, I consent to the "Missed Appointment Policy" + "MSP Assignment"

*Patient/Guardian signature*

*Date*

### **Please Indicate the Location of your Complaint**



## **HEALTH QUESTIONNAIRE**

Please list any medications you currently take:

Do you have a history of cardiovascular disease, or any other medical conditions?

Have you ever had any fractures? If yes, where and when?

Do you suffer from headaches?

Have you sought previous therapy for this complaint? (eg. Physiotherapy/Registered Massage Therapy)

Please add any additional comments that you'd like: