CHIROPRACTIC INTAKE FORM

Last Name	First Name	Email Address		
Is this your preferred name? ❑ Yes ❑ No	If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:	Gender Pronoun: ❑ He ❑ She ❑ They
Home address:		Phone Number ( )		
City: Province: Postal Code:		Personal Health Number (PHN):		
Occupation:	Employer:	Work Phone Number ( )		

Referred to clinic by (please check one box): ❑ Dr. ______________________ ❑ Google ❑ Yelp

❑ Friend/Family Member: ___________________________ ❑ Close to home/work ❑ Other: _________________________

Primary reason for your visit (Please Describe):

EXTENDED HEALTH INFORMATION FOR DIRECT BILLING

Extended Health Insurance Provider: ❑ Great West Life ❑ Sunlife ❑ Pacific Blue Cross ❑ Manulife ❑ Other: ___________________

Member ID: ______________________________ Policy/Plan Number: ______________________________________

Name of the Primary Card Holder: ____

Birthday of Primary Card Holder (MM.DD.YR): ____

Is today's visit related to an ICBC motor vehicle accident or WorkSafeBC injury?

❑ Yes
❑ 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.:
		( )	( )

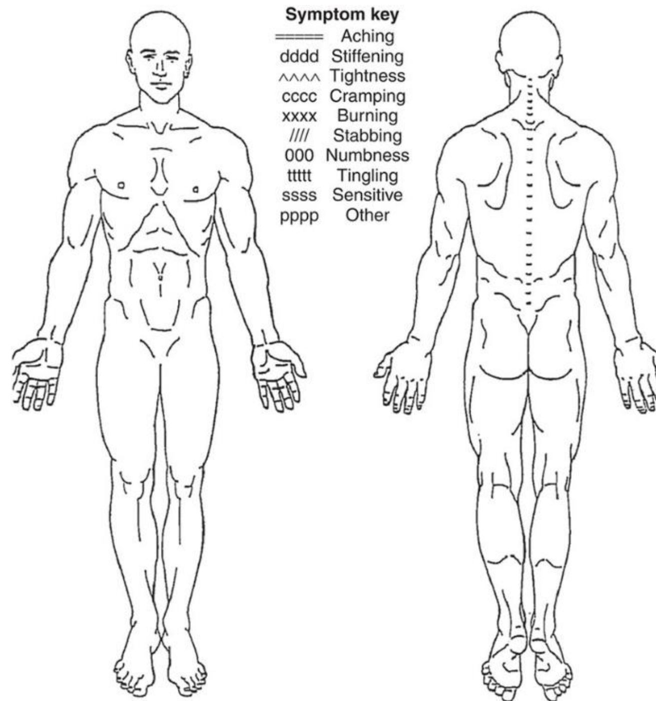
MSP ASSIGNMENT

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 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/Chiropractic)
Please add any additional comments that be relevant to your doctor: