NEW PATIENT ADMITTANCE RECORD

The information you provide is for the confidential use of this office and will only be released with your written consent.

Date _____ AHCIP _____

Name:Dr. Mr. Mrs. Ms _____

Address _____ City _____ Postal Code _____
Email address: _____ emergency contact #: _____
Telephone: Home _____ Cell _____ Work _____

Birthdate _____ Age _____

Marital Status:
Single____Cohabitating____Married____Divorced____Widowed____Separated____

Occupation _____

Name of Spouse _____ Children: Boys_____Girls_____

Name of Person who referred you to this office _____

Do your work tasks contribute to your health problems _____
Is this a Personal Injury Case? ____Yes____No If yes, indicate by circling the appropriate letter.

a) Motor Vehicle Accident (M.V.A.)
b) M.V.A. with possible legal involvement
c) Personal Injury with involvement (P.I.)
d) Your present physical complaints arose as the result of an injury that was severe enough to have caused broken bones or injury to internal organs.

Is this a work-related injury? Yes_____ No_____
If yes, we are not a Workers' Compensation Board (W.C.B.) clinic, therefore any fees incurred, during your visit, are your responsibility.

My Present Symptoms are: (please list) _____
_____
_____
Recent Falls: _____
_____
Recent Accidents: _____
_____
Last Physical: _____
Last Adjustment: _____
Current Medications Taken: _____
_____
Patient's Comments: _____

_____
Patient's Signature