Dr. David J. Ruegg
6497 Yonge St.
Churchill, ON L0L 1K0

CHIROPRACTIC PATIENT INTAKE FORM

Last Name: _____ First Name: _____
Address: _____ City/Town: _____
Province: _____ Postal Code: _____
Home Phone: _____
Cell Phone: _____ Email: _____
Date of Birth: _____ Occupation: _____
Employer's Name: _____ Employer's Phone: _____
Prior Chiropractic Care: _____ Phone: _____
Gender: ☐ Female ☐ Male ☐ Other

FAMILY PHYSICIAN

Name: _____ Phone: _____
Address: _____
How did you hear about us? ☐ Doctor Referral ☐ Sign ☐ Phone Book
☐ Friend ☐ Family Member ☐ Other

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: _____ Cell Phone: _____

FEE SCHEDULE

Chiropractic Assessment:..... $100 Chiropractic Subsequent Visit:.....$50
Re- Assessment:..... $65 Shockwave Therapy (3 visit protocol):.....$250

OUR CANCELLATION POLICY REQUIRES 24-HOUR NOTICE OR YOU WILL BE CHARGED 100% OF THE FEE.

This signed form and photocopies of this signed form will serve as authorization to Dr. David J. Ruegg to obtain/release medical information pertaining to myself from/to my family physician or other health care provider. It also serves as an agreement to provide payment to Dr. David J. Ruegg, at the time of each visit, and later claim through my extended health care benefits plan, as appropriate.

SIGNATURE: _____ DATE: _____

Patient Health History

Date and Nature of Injuries/Surguries: _____

Known Allergies(anaphylaxis or skin irritation) _____

Please check all applicable:

Cardiovascular Conditions

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Cardiovascular disease
- ☐ Phlebitis
- ☐ Heart attack
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Heart disease
- ☐ Pacemaker or similar device
- ☐ Other _____

Muscle/Joint Conditions

- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Tendinitis

Location _____

- ☐ Back pain
- ☐ Neck pain
- ☐ Leg pain
- ☐ Fibromyalgia
- ☐ Other _____

Systemic Conditions

- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Haemophilia
- ☐ Tuberculosis
- ☐ Other _____

Respiratory Conditions

- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other _____

Gastrointestinal

- ☐ Difficult digestion
- ☐ Nausea
- ☐ Constipation
- ☐ Gall bladder
- ☐ Colitis
- ☐ Other _____

Skin Conditions

- ☐ Bruises easily
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Infectious skin condition
- ☐ Other _____

Women's Conditions

- ☐ Pregnant (____wks)
- ☐ Menopause
- ☐ Dysmenorrhea
- ☐ PMS

Presence of:

- ☐ Internal pins
- ☐ Wires
- ☐ Artificial joints
- ☐ Other _____

Other Conditions

- ☐ Headaches
- ☐ Vision/Hearing loss
- ☐ Numbness

Location _____

Are there any other conditions/concerns you have? _____

_____

I understand that the information given on this form will be confidential and will be used solely for the professional therapists' clinical records.

Date _____ Signature _____