Dr. Jesse McAleese
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
Re- Assessment:.. $65
Chiropractic Subsequent Visit:...........................$50
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. Jesse McAleese 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 ______________________