SIMCOE COUNTY CHIROPRACTIC

DATE:_____ FILE NO:_____ DR. Ronald T. Linzner B.Sc., D.C.

1) LAST NAME_____ FIRST NAME_____
ADDRESS_____
CITY_____PROVINCE_____
POSTAL CODE_____PHONE #_____
BIRTH DATE ____/____/_____ EMAIL ADD._____M/F
DA MO YR

EMPLOYERS NAME_____
EMP. ADDRESS_____

2) DO YOU HAVE EXTENDED HEALTH CARE? (**YES/NO**)_____
If YES, INSURANCE CO._____ POLICY #_____

3) WHOM MAY WE THANK FOR REFERRING YOU?_____

4) FAMILY DOCTOR_____ PHONE #_____

5) WHAT PROBLEM CONCERNS YOU NOW?_____
IS IT THE RESULT OF A MOTOR VEHICLE ACCIDENT? **NO/YES** _____
IF YES, DATE _____/_____/_____ INS CO._____
POLICY #_____ CLAIM #_____
IS IT INVOLVING WORKMAN'S COMPENSATION? **NO/YES** _____
DATE_____/_____/_____ CLAIM #_____
SOCIAL INSURANCE # _____ _____ _____

6) HAVE YOU HAD X-RAYS? **NO** / **YES** RESULTS?_____

7) HAVE YOU HAD ANY OPERATIONS? _____

8) ARE YOU TAKING ANY MEDICATION? WHICH?_____

9) DO YOU HAVE ANY OF THE FOLLOWING? (**YES** OR **NO**) _____

CANCER OR TUMOR_____
EPILEPSY_____
ALLERGIES_____
KIDNEY PROBLEM_____
DIGESTIVE PROBLEM_____
DIABETES_____
HEART CONDITIONS_____

CIRCULATORY PROBLEM_____
BLOOD PRESSURE PROBLEM_____
RESPIRATORY PROBLEM_____
SKIN/HAIR PROBLEM_____
DO YOU USE ARCH SUPPORTS_____
DO YOU USE A BACK SUPPORT_____

10) HAVE YOU HAD THERAPY OR CHIROPRACTIC CARE? (**YES OR NO**)
WHERE? _____ WHEN?_____
BY WHOM_____ FOR WHAT?_____

PATIENT:_____ GAURDIAN (if<18yo)_____