

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 _____	CIRCULATORY PROBLEM _____
EPILEPSY _____	BLOOD PRESSURE PROBLEM _____
ALLERGIES _____	RESPIRATORY PROBLEM _____
KIDNEY PROBLEM _____	SKIN/HAIR PROBLEM _____
DIGESTIVE PROBLEM _____	DO YOU USE ARCH SUPPORTS _____
DIABETES _____	DO YOU USE A BACK SUPPORT _____
HEART CONDITIONS _____	

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

PATIENT: _____ GAURDIAN (if<18yo) _____