



2 Marsellus Dr. #15
Barrie, ON
L4N 0Y4

Tel/FAX: (705) 728 9999
info@hmchiropractic.ca
barriechiropractor.ca

Rates of Service

Initial visit, with or without treatment: \$95.00
Subsequent visit with treatment: \$50.00
Extended Chiropractic visit with treatment \$70
Custom Orthotics: \$400 +

Patient Information

Name: _____ Age: _____
Address: _____ Date of Birth: _____
City: _____ Province: _____ Postal Code: _____
Home Phone#: () _____ Cell Phone #: () _____
E-Mail Address: _____
May we have your permission to contact you via Email? (circle one): YES NO
Marital Status (circle one): Married Single Gender (circle one): M F
of Children: _____
Occupation: _____
Employer: _____ Work Phone #: () _____
Emergency Contact: _____ Phone #: () _____

Health History

Reason for seeking chiropractic care: _____
Date of Onset/Accident: _____
Is this condition due to a/an (circle one): Auto Accident Work Injury Other

Name of Family Physician _____ Phone # _____
May we contact your physician with regards to your chiropractic care? (circle one): YES NO

List any current medications: _____
List any past surgeries and dates: _____
List any past accidents and dates: _____
List any x-rays you have had in the past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? _____
If yes, Doctor's Name: _____ City: _____
Date of last visit: _____ Reason for care: _____

FEMALES: Is there any possibility of you being pregnant? _____

How did you hear about our clinic? _____

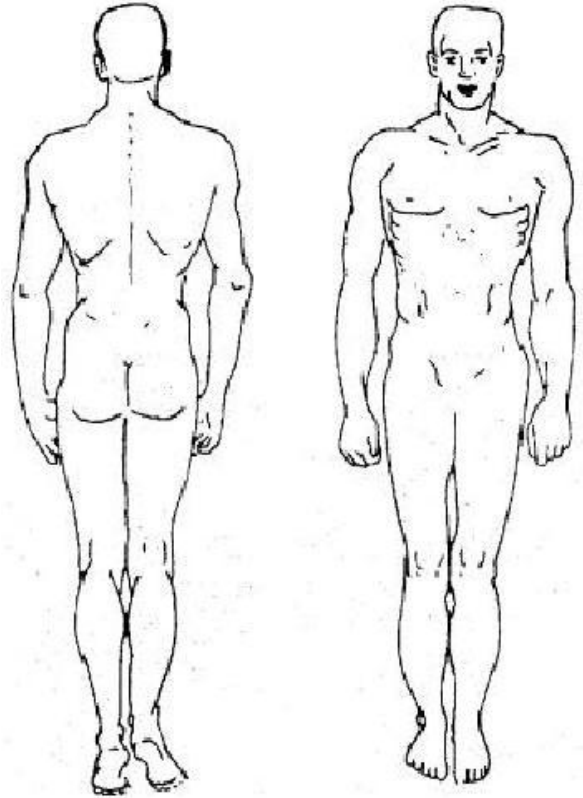
Dr. Jennifer Malowney, BSc, DC
Dr. Scott Best, BA, DC
Chiropractors
Tel/Fax: 705 728 9999

Patient Name
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If you have had the following, or if you suffer from the following, *Please Check*✓

- Headache
- Migraines
- Neck Pain
- Shoulder Pain
- Arm/Hand Pain
- Mid Back Pain
- Low Back Pain
- Hip Pain
- Leg/Foot Pain
- Arthritis
- Other joint pain
- Numbness
- Joint Swelling
- Dizziness
- Nausea
- Weakness
- Fatigue
- Nervousness
- Insomnia
- Heart Problems
- Vision Changes
- Nose Bleeds
- Ringing in Ears
- Earaches
- Hearing Loss
- Cough
- Chest pains
- HIV +, Hepatitis A, B, or C +
- Allergies
- Asthma
- Cancer
- Osteoporosis
- Diabetes
- Hypoglycemia
- Digestive problem
- Urinary Problems
- Frequent colds

Skin conditions
Please use "X's" to mark areas of pain or discomfort



Please rate your pain on a scale of:
0 (None) to 10 (Worst): _____

Please fill in any other health information you feel we might need for your care.

I understand that I am responsible for service fees in full at the time the services are rendered. I consent to an initial examination.

Patient Signature: _____

Date: _____

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