Hubbards Chiropractic
9977 St Margaret's Bay Road, Suite 213
Hubbards, NS
Phone: (902) 858-9977 Fax: (902) 858-2060
www.hubbardschiropractic.ca

Adult
Patient Intake Form

Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Date ___________________________

Last Name ________________________ First Name ________________________ Male ❑ Female ❑
Date of Birth _______________________ Health Card Number ______________________________
Address ____
City ____________________________ Province ___________________ Postal Code ___________________
Marital Status _______________________ # of Children ___________
Home Telephone (___) ________________________ Cell Phone (___) ______________
Business Telephone (___) ______________________
Employer ____________________________________ Occupation __________________________________
Email ____
May we add you to our email newsletter? Yes ❑ No ❑ (Your information will not be shared)
How would you prefer to receive your appointment reminders? Text ❑ Email ❑ Phone Call ❑

Emergency Contact ________________________Telephone ________________ Relation ________________
Employer ____________________________________ Occupation __________________________________

How did you hear about our clinic? Phone Book ❑ Website ❑ Friend ❑ Who? ______________________
Advertisement ❑ Brochure ❑ Other ❑ ________________________________

Private Health Insurance? Yes ❑ No ❑ Name of Carrier __________________ Policy#_________________
ID #_________________
Name of Family Doctor ______________________________________ Telephone ______________________
Address ____

Have you ever been treated by a chiropractor? Yes ❑ No ❑ If yes, when? __________________________
Facility Name __________________________ Doctor ____
Reason for treatment __________________________ Results ______________________________________

Please list other health care professionals from whom you are currently seeking care
Name ____________________________________ Specialty ____
Name ____________________________________ Specialty ____
Name ____________________________________ Specialty ____

Are you currently experiencing pain anywhere? No ❑ Yes ❑ Where? _______________________________
For how long? __________________________ Is it getting better or worse? __________________________
On a scale of 1-10 please rate the pain (10 is the worst) _______
What makes it worse? ________________________ What makes it better? __________________________
Have you had any x-rays or scans? ____

over →

Have you, your parents, siblings, or grandparents ever been diagnosed with:

❑ High Blood Pressure ❑ Diabetes ❑Thyroid Problems
❑ High Cholesterol ❑ Cancer ❑ Kidney Disease
❑ Heart Disease ❑ Stroke ❑ Arthritis
❑ Other ____

Lifestyle and Health History

Do you smoke? Yes ❑ How many packs per day? _____ No ❑ When did you quit? __________________
Do you consume alcohol? Yes ❑ _______ drinks per week No ❑

List any falls or accidents you have had ____
____
List all surgeries you have had with the dates ____
____
List all medications you are currently taking ____
____
List all vitamins and supplements you are currently taking ______________________________________
____

Is this injury a result of a motor vehicle accident? No ❑ Yes ❑ If yes, please give the following details:
Date of accident ___________________________ Insurance Company ______________________________
Name of adjuster __________________________ Claim # ____
-I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy. Furthermore, I understand that the chiropractor will prepare any necessary reports and forms to assist me in making collection for which there may be a normal fee charged to me.

Cancellation Policy

Because your appointment time is set aside for you, we ask that you respect our time and provide us with a minimum 24 hours notice if you have to cancel your appointment. This gives us time to schedule in someone from the waiting list. We reserve the right to charge the full visit fee for missed appointments. Exceptions to this policy include cancellations due to poor weather, illness, or family emergency as these events cannot be predicted.

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment at the time of the visit unless other arrangements with insurance companies have been made.

I am aware of the cancellation policy.

__________________________________ ____
Patient Signature Date
__________________________________Guardian Signature (if patient is a minor)