Back to Health

New Patient Information

Name: _____ Date: _____

Date of Birth: _____

Occupation: _____ Employer: _____

PO Box/Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Who may we thank for referring you? _____

Insurance Company: _____ Self / Spouse / Dependant

Group #: _____ ID/Certificate #: _____

Present complaint/illness:

_____

Present/Past Medical History

Have you or any of your first-degree relatives had or presently have any of the following conditions?

Rheumatic fever	Y/N	Fainting or dizziness with/without physical exertion	Y/N
Recent operation	Y/N	Diabetes	Y/N
Oedema (swelling of ankles)	Y/N	High cholesterol	Y/N
High blood pressure	Y/N	Shortness of breath at rest or with mild exertion	Y/N
Low blood pressure	Y/N	Chest pains	Y/N
Seizures	Y/N	Palpitations or tachycardia (unusually strong or rapid heartbeat)	Y/N
Lung disease	Y/N	Known heart murmur	Y/N
Heart attack	Y/N	Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side of your body	Y/N
Surgeries	Y/N	Traumas	Y/N

Please explain any YES, or other not listed:

_____

- Do you participate in regular exercise at this time? Yes ___ No ___ If yes, briefly describe:

_____

- Do you smoke? Yes ___ No ___ If yes, how much per day and for how long? _____

- List the medications you are presently taking _____

_____

- Do you have any Allergies? Yes ___ No ___ If yes, explain: _____

EMERGENCY CONTACT: _____ Relationship: _____ Phone: _____

DEBIT/CREDIT CARD AUTHORIZATION

In order for Back to Health to continue taking insurance on assignment we now require a credit/debit card number to secure any balances not received from your insurance company. I understand that I will be charged for late cancellations and no shows.

I, _____ authorize Back to Health to charge my card for the balance my insurance company did not pay. VISA/MC/DEBIT CARD #_____-_____-_____-_____ Expiry date_____

Signed_____ Date _____

Informed consent

The above information is true and accurate to the best of my knowledge. The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved, and the possibilities of complications will be fully explained to the patient. Tests, with or without x-rays, have been performed to minimize any risks to the patient. I acknowledge that no warranties or guarantees will be made to me concerning the results of the treatment. I acknowledge that the treatment is found to be necessary or desirable in the judgment of the professional. If you have any questions please ask. I have read the above statement and consent to treatment.

Patient/Legal Guardian Signature: _____ Date: _____