

Bowmanville Chiropractic Clinic

Dr. Robin L. Jeffrey B.Sc., D.C.

Confidential Patient History

Patient #: _____

(For internal use only)

Date: _____

PERSONAL INFORMATION

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ Work: _____ Cell: _____

Birth Date ____/____/____ Age: ____ Gender: M F
 D M Y

Business/Employer: _____ Type of Work/Duties: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office? _____

CURRENT HEALTH STATUS

Main health complaint: _____

Is your present condition the result of: Auto Accident / Work Injury / Personal Injury / Other (Please circle one)

When did this problem begin? _____

Other Doctors seen for this condition: _____ X-rays? _____

Have you received any other treatment for this condition? _____

Have you seen a Chiropractor previously? _____ If yes, date of last visit: _____

Medical Doctor's Name: _____

Please list all past and present medical conditions and medications you are currently taking:
