Patient Information

Dr. T.J. McKay, D.C.
Dr. K.B. Jenkins, D.C.
Dr. S. Bounket, D.C.

Date_____

E-mail Address: _____

☐ Please add me to the mailing list for appointment reminders, important health information, clinic updates and newsletters

Name:_____

Address: _____ City: _____ Postal Code: _____

Home/Cell Phone: _____ Business Phone: _____

Occupation or Profession: _____ Date of Birth: (DD/MM/YY) _____

Marital Status: S M W D Common-law Spouse Name:_____ Number of children:_____

Previous Chiropractic Care: Y☐ N☐ By Whom: _____ Last Seen: _____

Medical Practitioner: _____ Last Seen: _____

Alberta Health Care #: _____ Sex: M / F

Private Health Insurance? Y☐ N☐ Name of Company: _____

Who referred you to this office? _____

Is this a work related injury (WCB)? Y☐ N☐ Has your employer been notified? Y☐ N☐

Is this a Motor Vehicle Accident (MVA)? Y☐ N☐ On what date did the accident occur? _____

Have you ever had any falls, accidents, or injuries (including MVA/WCB)? Y☐ N☐ If yes, please explain: _____

_____

Have you ever had surgery? Y☐ N☐ If yes, please explain and give dates: _____

_____

Please list any previous or current illnesses: _____

_____

_____

Medication presently taking: _____

_____

Purpose of visit/primary complaints: _____

Do you have any health problems that you think chiropractic cannot help? _____

_____

I clearly understand and agree that all services rendered to me, that are not covered by insurance or WCB, are charged directly to my account, and that I am responsible for payment of services as they are performed.

Patient Signature: _____

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