Metrotown Family Chiropractic
202 - 6411 Nelson Avenue
Burnaby, B.C. V5H 4H3
(Tel) 604.430.1525 (Fax) 604.430.3911
www.metrotownchiropratic.com

CONFIDENTIAL PATIENT INFORMATION

Last Name	First Name	Email Address		
Is this your preferred name? ☐ Yes ☐ No	If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:	Gender Pronoun: ☐ He ☐ She ☐ They
Apt #:	Address:	Cell # ( )		
City:	Province:	Postal Code:	Personal Health Number (PHN):	
Occupation:	Employer:	Work Phone Number ( )		

Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Google ☐ Yelp

☐ Friend/Family Member: _____ ☐ Close to home/work ☐ Other: _____

EXTENDED HEALTH INFORMATION FOR DIRECT BILLING

Extended Health Insurance Provider: ❑ Canada Life ❑ Sunlife ❑ Pacific Blue Cross ❑ Manulife ❑ Other: _____

Policy/Plan Number: _____ Member ID: _____

Name of the Primary Card Holder: _____

Birthday of Primary Card Holder (MM.DD.YR): _____

Is today's visit related to an ICBC motor vehicle accident or WorkSafeBC injury?
☐ Yes
☐ No

If **YES**, please list the following:

Date of the Accident (MM.DD.YR): _____

Claim Number: _____

MSP ASSIGNMENT

I authorize Medical Services Plan to pay Metrotown Family Chiropractic directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me at this clinic. I make this assignment in full knowledge of the amount that I will personally be responsible for and the amount that is reimbursable by the Medical Services Plan which will be directed to Metrotown Family Chiropractic to be applied against any outstanding monies I owe for services provided.

By Signing below, I consent to MSP Assignment

Patient/Guardian signature *Date*

PERMISSIONS

Initials _____ I give permission for you to communicate clinical information relevant to my care at this office with my medical doctor _____.

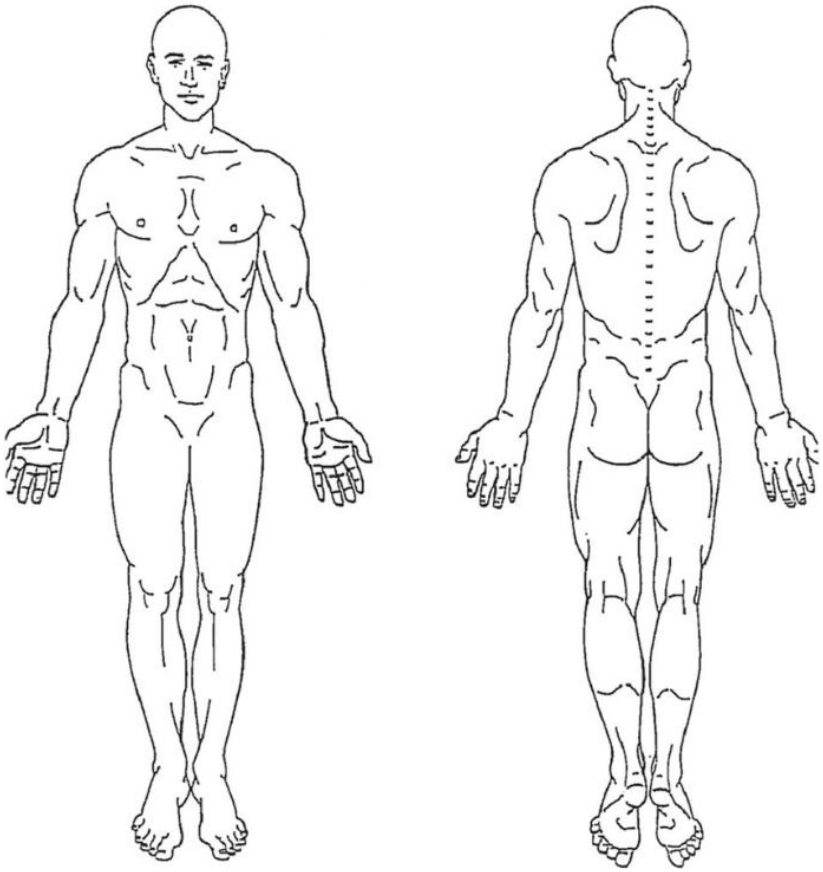
Initials _____ I grant permission to be called to reschedule an appointment; and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office, appointment reminders, and/statements.

Initials _____ I grant permission for my extended health insurance to be electronically submitted on my behalf.

PLEASE CHOOSE WHAT YOU PREFER

Statements	☐ Electronically Sent	☐ Printed	☐ No Statement/Only When Requested
Appointment Reminders	☐ Email	☐ Text Message	☐ No Reminder

Please **Circle** the Location of your Complaint



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REASON(S) FOR YOUR VISIT

What is your top complaint today?	When did it start? (Chronic or Acute)	Did it get worse recently? (If no, why here today?)	What happened? (Injury)
1.			
2.			

Intensity: **1**. ____ /10 **2**. ____ /10

How is this condition affecting you? _____

What aggravates your condition? _____

Circle: Numbness / Tingling / Radiation **Where**: _____ **How Long?** _____

HEALTH QUESTIONNAIRE
Have you ever had any fractures? If yes, where and when?
Do you suffer from headaches?
Have you been experiencing foot pain, fatigue, or tension recently? If yes, how long? Which foot and where? Intensity /10?
Have you sought previous therapy for this complaint? (eg. Physiotherapy/Registered Massage Therapy/Chiropractic)
Please list any current medications and provide details about any history of cardiovascular disease or other medical conditions.
Please add any additional comments that be relevant to your doctor:

Tech Notes: _____

_____

_____

_____ **Prone Leg Length**: _____

Tech's signature: _____ Date: _____