Lockport Family Chiropractic

Health & Wellness Centre

PATIENT ENTRANCE FORM

Name: _____ Date: _____

Address: _____
(Street) (City) (Province) (Postal Code)

Home Phone: _____ Cell Phone: _____

Date of Birth (D/M/Y): _____ Age: _____ Marital Status: S M D W

Email Address: _____

Manitoba Health #: _____ P.H.I.N.# _____

Occupation: _____

Employer: _____

Spouses Name: _____ Children: _____

Emergency Contact: _____ Phone: _____

How did you hear about our office: Referred by _____ Internet _____ Sign _____

Will claim be made against:

1. Recent motor vehicle accident: Yes _____ No _____ (if Yes, see attached)

2. Work related injury/accident: Yes _____ No _____ (if Yes, see attached)

Prior Chiropractic care

Name: _____ Phone: _____

How many visits since the first of this year: _____ Did you receive relief: Y / N

X-rays taken: Yes _____ No _____ Date: _____

Medical Doctor

Name: _____ Phone: _____

Address: _____

Date of last appointment: _____ Date of last physical: _____