438 Division St. Cobourg, ON Phone: (289) 222-9798

Muller Chiropractic
*We've got your back*

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name:_____Age:_____ Date of birth: _____

Address:_____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Business: _____

We will use the minimum necessary amount of protected health information in any communication. I consent receiving reminder and occasional notification via email. I understand I can withdraw my consent at any time.

My email address is: _____

Occupation: _____ Employer's Name: _____

Marital Status: (S) (CL) (M) (D) (W) Name of Spouse/Partner: _____ Children? (N) (Y) How many?_____

Who may we thank for referring you to our office?_____

Name(s) of previous chiropractor(s): _____ When was your last visit? _____
Reason: _____How long were you going for? _____

Name of Family doctor:_____

**Your Health Profile:**

What health concerns do you feel we can address for you? _____

When did this episode start? _____ Have you had this before and when? _____

Since this began, is it worse, better or about the same? _____

What makes it worse? _____ What makes it better? _____

Does this condition interfere with your (please circle): work • school • leisure • sleep sports/exercise • other: _____

Other doctors seen for this condition:

Name: _____ Date: _____ Diagnosis:_____

**General History:**

Are you currently seeing any other health practitioners as part of your health care team? _____

Medical doctor Naturopath Acupuncturist Registered Massage Therapist Other: _____

Please list any accidents and/or injuries (Automobile, bicycle, sports, playground, etc.) and the date of the injury:

_____ Date: _____

Please list any surgeries you have had and the date of the surgery:

_____ Date: _____

**Birth Record:**

Were there any complications during your mother's pregnancy or during your birth? _____

What type of birth did you have (vaginal, c-section, forceps, etc.)? _____

Are you pregnant? Y N If yes, when is your due date?

**Extended Health Insurance - Direct Billing:** Direct billing may be available to you. Please provide your insurance information: Name of insurance_____ Policy number_____ Member ID_____

Are you the insured member? Y N If not, please provide member's full name_____ and date of birth_____

**General Health:**

How would you describe your current health? _____

How would you describe your family's health? _____

Do you use any of the following (Please circle)? Tobacco Alcohol Coffee/Tea Soft drinks Milk

Level of stress in your life (1-10): ___ Is your health better, worse or the same as 5 years ago? _____

Explain why you think this is: _____

**Goals and Expectations:**

People visit a chiropractor for a variety of reasons. To serve you better, we'd like to know which of the following health care options you are most interested in and intend to follow through with. Please check which description suits you best:

- ☐ Preventative Care – Wellness and life enhancement care
- ☐ Maintenance Care- Removing symptoms and their cause, with periodic routine maintenance visits
- ☐ Relief Care- Band-aid care to remove symptoms only
- ☐ Unsure, I would like the doctor to select the type of care that is most appropriate for my condition.

**Muller Chiropractic** is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (289) 222-9798 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, a $30 fee is applied for the missed appointment. We appreciate your consideration.

Patient's Signature _____ Date: _____