2 Marsellus Dr. #15
Barrie, ON
L4N 0Y4

Tel/FAX: (705) 728 9999
info@hmchiropractic.ca
barriechiropractor.ca

Rates of Service

Initial visit, with or without treatment: $95.00
Subsequent visit with treatment: $50.00
Extended Chiropractic visit with treatment $70
Custom Orthotics: $400 +

Patient Information

Name: _____ Age: _____
Address: _____ Date of Birth: _____
City: _____ Province: _____ Postal Code: _____
Home Phone#: (__) _____ Cell Phone #: (__) _____
E-Mail Address: _____
May we have your permission to contact you via Email? (circle one): YES NO
Marital Status (circle one): Married Single Gender (circle one): M F
# of Children: _____
Occupation: _____
Employer: _____ Work Phone #: (__) _____
Emergency Contact: _____Phone #: (__) _____

Health History

Reason for seeking chiropractic care: _____
Date of Onset/Accident: _____
Is this condition due to a/an (circle one): Auto Accident Work Injury Other

Name of Family Physician _____Phone #_____
May we contact your physician with regards to your chiropractic care? (circle one): YES NO

List any current medications: _____
List any past surgeries and dates: _____
List any past accidents and dates: _____
List any x-rays you have had in the past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? _____
If yes, Doctor's Name: _____City: _____
Date of last visit: _____Reason for care: _____

FEMALES: Is there any possibility of you being pregnant? _____

How did you hear about our clinic? _____

Dr. Jennifer Malowney, BSc, DC
Dr. Scott Best, BA, DC
Chiropractors
Tel/Fax: 705 728 9999

Patient Name _____

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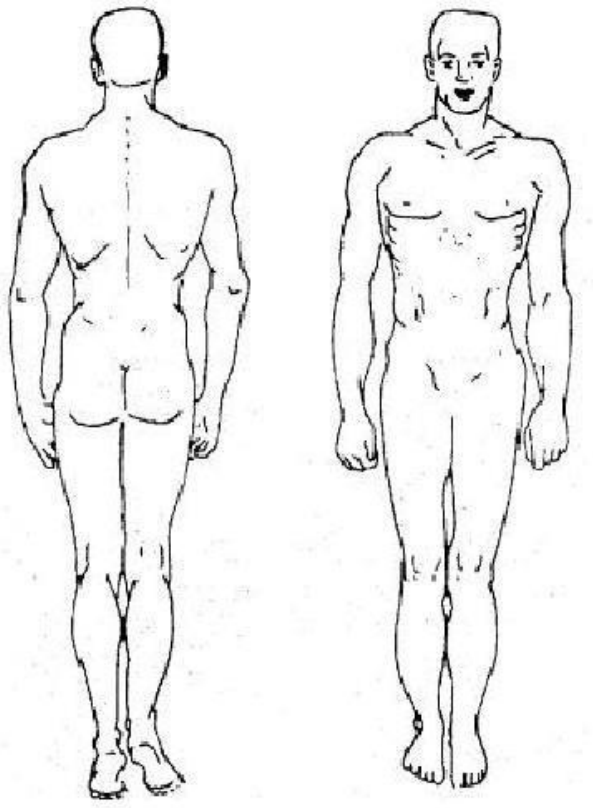
If you have had the following, or if you suffer from the following, *Please Check*✓

Headache❑
Migraines❑
Neck Pain❑
Shoulder Pain❑
Arm/Hand Pain❑
Mid Back Pain❑
Low Back Pain❑
Hip Pain❑
Leg/Foot Pain❑
Arthritis❑
Other joint pain❑
Numbness❑
Joint Swelling❑
Dizziness❑
Nausea❑
Weakness❑
Fatigue❑
Nervousness❑
Insomnia❑
Heart Problems❑
Vision Changes❑
Nose Bleeds❑
Ringing in Ears❑
Earaches❑
Hearing Loss❑
Cough❑
Chest pains❑
HIV +, Hepatitis A, B, or C +❑
Allergies❑
Asthma❑
Cancer ❑
Osteoporosis❑
Diabetes❑
Hypoglycemia❑
Digestive problem❑
Urinary Problems❑
Frequent colds❑

Skin conditions❑

Please use "X's" to mark areas of pain or discomfort



Please rate your pain on a scale of:
0 (None) to 10 (Worst): _____

Please fill in any other health information you feel we might need for your care.

I understand that I am responsible for service fees in full at the time the services are rendered. I consent to an initial examination.
Patient Signature: _____
Date: _____

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