DOCWELLNESS.COM INC.

DR. PATRICK F. HEWITT, CHIROPRACTOR

CONFIDENTIAL CHIROPRACTIC CLIENT INFORMATION FORM

((PLEASE PRINT CLEARLY!)

FULL NAME:			
HOME ADDRESS:			
TOWN/CITY:	POSTAL CODE:		
PHONE NUMBERS	EMAIL:		
RESIDENCE:	DATE OF BIRTH		
MOBILE:	DAY	MONTH	YEAR
WORK: EXTN:			
WHO REFERRED YOU TO THIS CLINIC?			

Dear Client;

The ability to draw effective conclusions about your present state of health can give significant insight into the best approach to your case and best plan of action for your care. All of this is made easier by your careful, accurate and thoughtful responses to the attached questions, and those posed during your consultation.

If Dr. Hewitt determines that Chiropractic Care is appropriate in your case, there will be further, more comprehensive forms to complete prior to your full examination.

If Dr. Hewitt determines that Chiropractic Care is not the best fit for your Health concerns, he may refer you to other Health Professionals within or outside of this clinic, or give you advice on which Health Care Services you should seek.

PLEASE NOTE YOUR PRESENT REASON FOR CONSULTING THIS OFFICE

☐ I am here for a Chiropractic Assessment to investigate what role Chiropractic can play in my wellness plan.

☐ I need help with a specific health concern and I need to understand how to prevent this problem in the future.

☐ I have a unique reason for being here: _____

PARENTS AND GUARDIANS

I, (print name) _____, have brought my child (named above) for an assessment and to investigate the role this clinic can play in my child's health, development and wellness.

signed _____ dated (dd/mm/yy)_____

PLEASE FLIP THE PAGE OVER TO COMPLETE THE OTHER SIDE OF THIS FORM!

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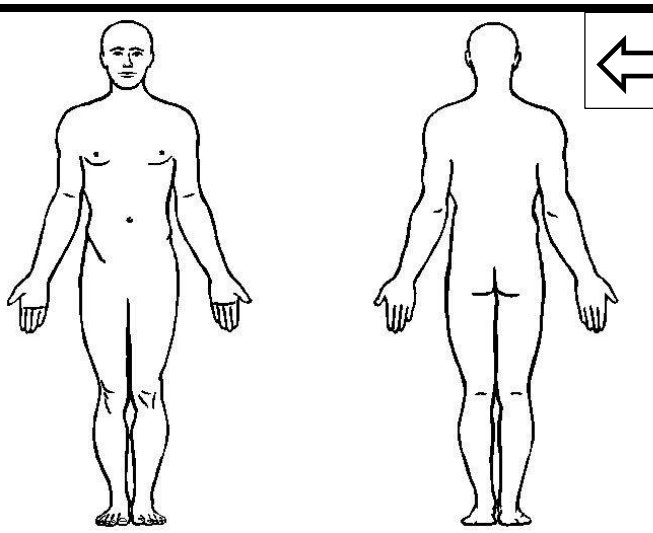
DESCRIBE, AS BEST YOU CAN, YOUR CURRENT HEALTH CONCERN, IN DETAIL:

HOW DO YOU THINK IT STARTED?

❑WAS IT CAUSED BY A CAR ACCIDENT?	❑WAS IT CAUSED BY A WORK ACCIDENT?
❑WAS IT REPORTED TO THE POLICE?	❑WAS IT REPORTED AS A W.S.I.B. CASE?
❑WAS IT REPORTED TO YOUR INSURANCE CARRIER?	❑ARE YOU OFF WORK AS A RESULT OF THIS ACCIDENT?



Mark the location and character of any symptoms you are experiencing on the adjacent diagram, using these symbols ⇩

****	ACHE	STAB	∇∇∇∇
■■■■	BURN	STIFF	≡≡≡≡≡
↯↯↯↯	ELECTRIC	SWOLLEN	Circle (the) area
••••••	NUMB		
⇔	PULL	THROB	((bracket the area))

Also, feel free to make any other notes on the diagram to help us understand your current state.

WHEN IS YOUR PROBLEM MOST SIGNIFICANT?

☐a.m. ☐p.m. ☐while sleeping ☐in the morning ☐standing
☐getting up from a chair ☐leaning forward ☐cough/sneeze

WOMEN ONLY: ☐@ovulation ☐@onset ☐@menstruation

HOW OFTEN DOES THIS HAPPEN?	NEVER … RARLEY … YEARLY … MONTHLY … WEEKLY … DAILY … HOURLY … CONSTANT
HOW LONG DOES IT USUALLY LAST?	SECONDS … MINUTES … HOURS … DAYS … WEEKS … YEARS … CONSTANT
HOW INTENSE ARE THE SYMPATOMS?	BOTHERSOME … LIMITS SPECIFIC ACTIVITY … LIMITS MOST ACTIVITY … STOPS EVERYTHING
IS YOUR CONDITION….?	IMPROVING… BETTER, … BUT VARIES NO CHANGE … WORSE,… BUT VARIES WORSE … RAPIDLY DETERIORATING!

WHAT MAKES YOUR CONDITION WORSE?
WHAT MAKES YOUR CONDITION BETTER?

ARE YOU USING ANY OTHER CARE, DRUGS, REMEDIES OR SUPPLEMENTS FOR THIS CONDITION?

TREATMENT OR PRODUCT&DOSAGE	REASON	PRESCRIBED BY…	STARTED	PROGRESS?	COMMENTS OR INSIGHTS?

XRAYS, CAT SCANS, MRI'S AND TESTS

REASON / REQUESTED BY	(DD/MM/YY)	LOCATION	RESULTS