MASON HEALTH CENTRE

Dr. Michael Hamilton D.C

1070 Main Street West
Hamilton, Ontario
L8S 1B3
905-523-5010

NAME: ______________________________ DATE: ______________
WHAT DO YOU PREFER TO BE CALLED? ______________ ADDRESS: ______________
CITY: ______________ PROVINCE: ______________POSTAL CODE: ______________
MEDICAL DOCTOR & PHONE NUMBER: ______________________________
DATE OF BIRTH: ______________________ AGE: ________ GENDER: ________
MARITAL STATUS: ______________________ STUDENT YES _______ NO _______
HOME NUMBER: ______________ BUSINESS NUMBER: ______________
MOBILE NUMBER: ______________EMAIL ADDRESS: ______________
WHOM MAY WE THANK FOR REFERING YOU? ______________________________

RESPONSIBLE PARTY (*PLEASE COMPLETE IF DIFERENT FROM ABOVE*)

NAME: ______________________ RELATIONSHIP TO PATIENT: ______________
ADDRESS: ______________________ PHONE NUMBER: ______________

INSURANCE INFORMATION

NAME OF INSURED: ______________________ DATE OF BIRTH: ______________
INSURANCE COMPANY: ______________________ PHONE NUMBER: ______________
GROUP/INDIVIDUAL POLICY # ______________CERTIFICATE # ______________
DO YOU HAVE ADDITIONAL INSURANCE? YES _______ NO _______

(*PLEASE COMPLETE IF DIFERENT FROM ABOVE)*
NAME OF INSURED: ______________________ DATE OF BIRTH: ______________
INSURANCE COMPANY: ______________________ PHONE NUMBER: ______________
GROUP/INDIVIDUAL POLICY # ______________CERTIFICATE # ______________

HEALTH HISTORY

PURPOSE OF APPOINTMENT ______________________________
WHEN DID THIS CONDITION BEGIN? ______________________________
IF DISABLED FROM WORK, PLEASE GIVE DATES ______________________________
IS THE INJURY JOB RELATED _______ AUTO RELATED _______ DATE OF ACCIDENT/INJURY ______________
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? ______________________________
____
MAJOR SUGERY/OPERATIONS? ______________________________
MAJOR ACCIDENTS/FALLS? ______________________________
HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES _______ NO_______ LAST VISIT ______________
HAVE YOU HAD PREVIOUS MASSAGE THERAPY? YES_______ NO _______ LAST VISIT ______________
ARE YOU CURRENTY BEING TREATED FOR A HEALTH CONDITION? YES _______ NO _______
PLEASE EXPLAIN ______________________________

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

_____ RHEUMATIC HEART DISEASE OR RUMATIC FEVER
_____ HEART DEFECT OR HEART MURMUR
_____ HEART TROUBLE, HEART ATTACK OR ANGINA
_____ HEART SURGERY
_____ CONGENTIAL HEART PROBLEM
_____ CHEST PAIN
_____ SHORTNESS OF BREATH
_____ PACEMAKER
_____ HIGH/LOW BLOOD PRESSURE
_____ SWELLING OF FEET OR ANKLES, HANDS
_____ HEPATITIS, JAUNDICE OR LIVER DISEASE
_____ CHEMICAL DEPENDANCY
_____ NERVOUSNESS
_____ MENTAL HEALTH CARE

_____ LUNG OR BREATHING PROBLEMS
_____ ASTHMA OR HAY FEVER
_____ STROKE
_____ FAINTING OR DIZZY SPELLS
_____ DIABETES
_____ AIDS OR HIV INFECTION
_____ THYROID PROBLEMS
_____ ARTHRITIS OR RHEUMATISM
_____ JOINT REPLACEMENT
_____ CHEMOTHERAPY (CANCER, LEUKEMIA)
_____ EPILEPSY OR SEIZURES -
_____ HYPOGLYCEMIA
_____ ANEMIA
_____ EATING DISORDERS

WOMAN ONLY

ARE YOU PREGNANT OR YOU THINK YOU MAY BE PREGNANT? YES________ # OF WEEKS ________ NO________
WHEN WAS YOUR LAST PERIOD? ____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS

_____ LOW BACK PAIN
_____ NECK PAIN
_____ ARM PAIN
_____ LEG PAIN
_____ PAIN BETWEEN SHOULDERS
_____ HEADACHES
_____ JOINT PAIN/STIFFNESS
_____ WALKING PROBLEMS
_____ NUMBNESS
_____ PARALYSIS
_____ DIZZINESS
_____ JAW PAIN
_____ DIFFICULT CHEWING/CLICKING JAW

_____ FORGETFULNESS
_____ CONFUSION/DEPRESSION
_____ COVULSIONS
_____ COLD/TINGLING EXTREMITIES
_____ DIFFICULT CHEWING/CLICKING JAW
_____ STRESS
_____ FATIGUE
_____ ALLERGIES
_____ LOSS OF SLEEP
_____ FEVER
_____ HEADACHES
_____ HEARTBURN
_____ VARICOSE VEINS

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATLEY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

SIGNATURE OF PATIENT OR PARENT IF MINOR (*Under 16 Years of age*)

NAME (Please print)________________________________ SIGNATURE ________________________________

DATE ________________________