**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: (M/D/Y)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT YES / NO HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BUSINESS NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHOM MAY WE THANK FOR REFERING YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP/INDIVIDUAL POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFICATE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE? YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP/INDIVIDUAL POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFICATE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

PURPOSE OF APPOINTMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN DID THIS CONDITION BEGIN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THE INJURY JOB RELATED? PLEASE GIVE DATES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THE INJURY AUTO RELATED? DATE OF ACCIDENT/INJURY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND LIST WHAT THEY ARE FOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TURN OVER TO COMPLETE**

MAJOR SURGERY/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 CURRENTLY BEING TREATED FOR A HEALTH CONDITION? YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

PLEASE EXPLAIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?**

\_\_\_\_\_\_ RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER \_\_\_\_\_\_ LUNG OR BREATHING PROBLEMS

\_\_\_\_\_\_ HEART DEFECT OR HEART MURMUR \_\_\_\_\_\_ ASTHMA OR HAY FEVER

\_\_\_\_\_\_ HEART TROUBLE, HEART ATTACK OR ANGINA \_\_\_\_\_\_ STROKE

\_\_\_\_\_\_ HEART SURGERY \_\_\_\_\_\_ FAINTING OR DIZZY SPELLS

\_\_\_\_\_\_ CONGENTIAL HEART PROBLEM \_\_\_\_\_\_ DIABETES

\_\_\_\_\_\_ CHEST PAIN \_\_\_\_\_\_ AIDS OR HIV INFECTION

\_\_\_\_\_\_ SHORTNESS OF BREATH \_\_\_\_\_\_ THYROID PROBLEMS

\_\_\_\_\_\_ PACEMAKER \_\_\_\_\_\_ ARTHRITIS OR RHEUMATISM

\_\_\_\_\_\_ HIGH/LOW BLOOD PRESSURE \_\_\_\_\_\_ JOINT REPLACEMENT

\_\_\_\_\_\_ SWELLING OF FEET OR ANKLES, HANDS \_\_\_\_\_\_ CHEMOTHERAPY (CANCER, LEUKEMIA)

\_\_\_\_\_\_ HEPATITIS, JAUNDICE OR LIVER DISEASE \_\_\_\_\_\_ EPILEPSY OR SEIZURES -\_\_\_\_\_\_ CHEMICAL DEPENDANCY \_\_\_\_\_\_ HYPOGLYCEMIA

\_\_\_\_\_\_ NERVOUSNESS \_\_\_\_\_\_ ANEMIA

\_\_\_\_\_\_ MENTAL HEALTH CARE \_\_\_\_\_\_ 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 \_\_\_\_\_\_ FORGETFULNESS

\_\_\_\_\_\_ NECK PAIN \_\_\_\_\_\_ CONFUSION/DEPRESSION

\_\_\_\_\_\_ ARM PAIN \_\_\_\_\_\_ CONVULSIONS

\_\_\_\_\_\_ LEG PAIN \_\_\_\_\_\_ COLD/TINGLING EXTREMITIES

\_\_\_\_\_\_ PAIN BETWEEN SHOULDERS

\_\_\_\_\_\_ HEADACHES \_\_\_\_\_\_ STRESS

\_\_\_\_\_\_ JOINT PAIN/STIFFNESS \_\_\_\_\_\_ FATIGUE

\_\_\_\_\_\_ WALKING PROBLEMS \_\_\_\_\_\_ ALLERGIES

\_\_\_\_\_\_ NUMBNESS \_\_\_\_\_\_ LOSS OF SLEEP

\_\_\_\_\_\_ PARALYSIS \_\_\_\_\_\_ FEVER

\_\_\_\_\_\_ DIZZINESS \_\_\_\_\_\_ HEADACHES

\_\_\_\_\_\_ JAW PAIN \_\_\_\_\_\_ HEARTBURN

\_\_\_\_\_\_ DIFFICULTY CHEWING/CLICKING JAW \_\_\_\_\_\_ VARICOSE VEINS

**AUTHORIZATION**

**I UNDERSTAND MASON HEALTH CENTRE HAS A CANCELLATION POLICY OF 24 HOUR NOTICE, YOU MAY BE CHARGED IF PRIOR NOTIFICATION IS NOT GIVEN.**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**