

Dr. Mark Tran
 103 – 3 Father David Bauer Drive
 Waterloo, ON N2L 6M1
 (519) 954-8850

NEW PATIENT FORM



Thank you for choosing Achieve Wellness Centre.

We provide quality chiropractic care. Treatment is provided by Dr. Mark Tran. Direct and open communication between you and chiropractor is very important. Please tell us if: you require someone other than your chiropractor to be present during your treatment, or if you feel uncomfortable with the touch aspects of chiropractic therapy.

Please tell us about yourself

Mr. Mrs. Miss. Ms Dr.

Gender: MALE FEMALE OTHER: _____

Last name: _____
 First name: _____
 Date of birth: Day: _____ Month: _____ Year: _____
 Address: _____
 _____ Apt #: _____
 City: _____ Postal Code: _____
 Phone: Home: (_____) _____ Work: (_____) _____
 Email address: _____
 Emergency Contact: _____ Phone: (_____) _____
 What is your occupation: _____

Previous chiropractic experience

Previous chiropractor's name: _____
 Previous chiropractor's telephone: _____
 Date of last chiropractic visit: _____
 Medical doctor's name: _____
 Medical doctor's telephone: _____

I consent to allow Dr. Mark Tran to contact my medical doctor about my health care.

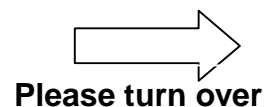
Patient: _____
Signature

Witness: _____
Signature

How did you hear about us?

We are pleased that you have chosen to come and see us! Please take some time to let us know how you found out about the Achieve Wellness Centre:

Magazine Newspaper Internet Yellowpages
 Outreach Program Signage Friend or Relative
 Other: _____



Billing information

Health Insurance Information

Do you have extended healthcare insurance? Yes No
(If not, you do NOT need to fill in the following information)

Insurer's name: _____

Policy #: _____

Member #: _____

Type of injury

Is this a Workplace Safety & Insurance Board injury? Yes No
(If not, you do NOT need to fill in the following information)

What is your social insurance number? _____

WSIB claim number? _____ Date of accident: _____

Employer's name: _____

Employer's address and telephone: _____

Type of injury

Are your injuries related to a motor vehicle case? Yes No
(If not, you do NOT need to fill in the following information)

Date of accident: _____

Insurer's name: _____

Policy or claim #: _____

Insurer's address and telephone: _____

Consent

I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

Date: _____ Guardian: _____

If patient is under 18 years of age

Please note:

All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for chiropractic services. We will issue a receipt for each payment for this purpose.

Health Status Survey



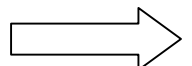
Patient Name: _____ **File #:** _____

Date: _____

Please **check** the box for any conditions or symptoms **presently** causing you problems.
 Please **X** the box for those conditions or symptoms **that you have had in the past**.

General Symptoms	Respiratory	Skin
Loss of consciousness	Asthma	Rashes/itching
Blackouts	Chronic cough	Bruise easy
Headache	Spitting up phlegm	Dryness
Fever	Spitting up blood	Boils
Excess sweating	Difficulty breathing	Hives (allergies)
Night sweats	Cardiovascular	Gastrointestinal
Loss of weight	Bleeding disorder	Poor appetite
Night pain	High blood pressure	Indigestion
Generalized pain	Chest pain	Excess hunger
Nervousness	Stroke	Belching or gas
Convulsions	Hardening of arteries	Vomiting
Loss of sleep	Varicose veins	Pain over stomach
Neurologic	Swelling of ankles	Constipation
Dizziness	Poor circulation	Diarrhea
Fainting	Heart/blood disease	Hemorrhoids (piles)
Problem speaking	Angina	Jaundice
Problem swallowing	Genitourinary	Gall bladder trouble
Blurred vision	Trouble urinating	Intestinal worms
Double vision	Blood in urine	Ulcer
Nausea	Kidney infection	Diabetes
Clumsiness	Bedwetting	Have you ever had any fractures? yes no
Numbness or tingling	Prostate trouble	If yes - where?
Muscles and Joints	GU for Women	Have you ever been in a car accident? yes no
Sore/stiff neck	Painful menstruation	If yes - when?
Mid back ache	Excessive flow	Have you ever been hospitalized? yes no
Low back ache	Hot flashes	Why/When?
Painful tailbone	Irregular/absent cycle	Are you currently a smoker? yes no How much? _____
Shoulder pain	Cramping/backache	Did you smoke previously? yes no How much? _____
Arm/forearm pain	Vaginal discharge	Have you ever been diagnosed: With cancer? yes no
Elbow pain	Swollen breasts	With HIV/AIDS? yes no
Wrist/hand pain	Lump in breasts	With Hep A/B/C? yes no
Hip pain	Currently on birth control pills/patch? yes no	
Knee pain	Previously on birth control pills/patch? yes no	
Ankle/foot trouble	# of pregnancies _____	
Arthritis	# of children _____	
Loss of strength		
Eyes/Ears/Nose/Throat	Medications (list):	
Failing vision		
Eye pain		
Failing hearing		
Earache	Clinician Comments:	
Ring/buzz in ears		
Frequent colds		
Sinus infection		
Enlarged thyroid		
Enlarged glands		

Please turn over



Symptom Diagram

Pt. Name: _____ File #: _____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best, represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.

Symbols:

Numbness ≡≡≡≡≡≡

Pins and Needles ○○○○

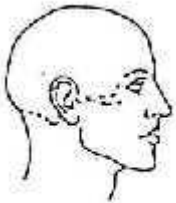
Burning x x x x x

Stabbing & Sharp ~ ~ ~ ~

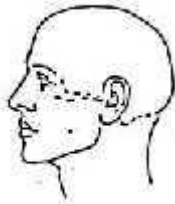
Dull & Aching △ △ △ △ △

Stiff & Tight 2 2 2 2 2

R

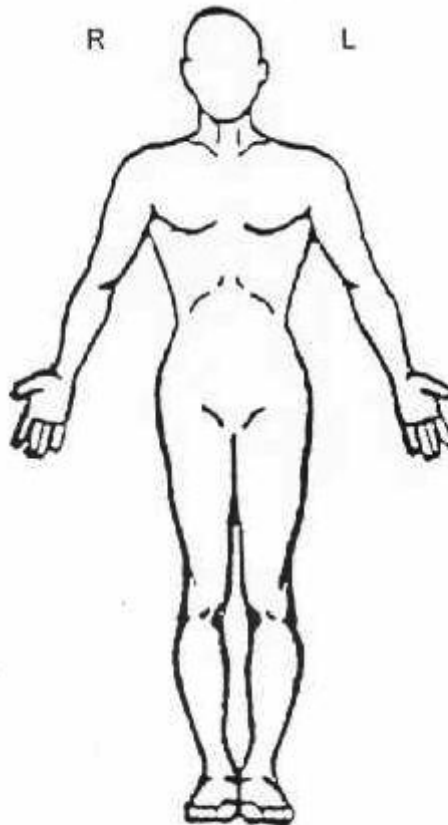


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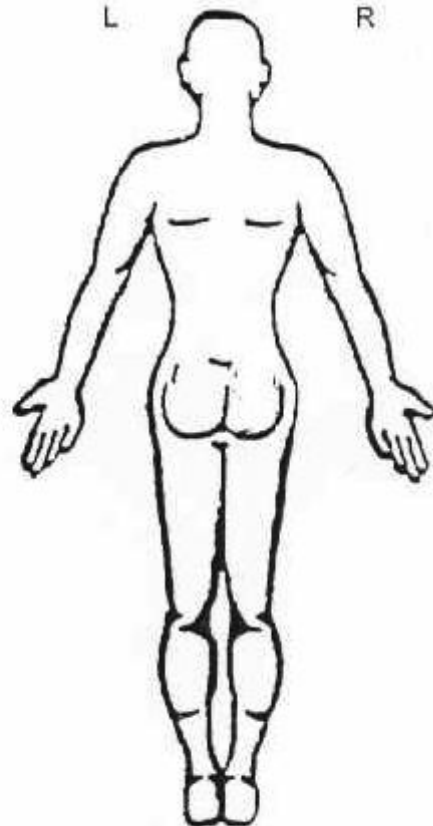
L



Front

L

R



Back