

Arthur Chiropractic Dr. Sean Lisk, D.C.

124B George St.
Arthur, ON, N0G 1A0

Tel: (519) 848-2451

Patient Information

Name: _____ Date of Birth: _____
Address: _____ Home Phone#: (__) _____
City: _____ Province: _____ Postal Code: _____
E-Mail Address: _____ Mobile Phone#: (__) _____
Marital Status (circle one): Married Single Gender (circle one): M F
of Children: _____
Occupation: _____ Extended Health Coverage: YES NO
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 to discuss your chiropractic care? YES NO

List any current medications: _____
List any past surgeries and dates: _____
List any past motor vehicle 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: _____

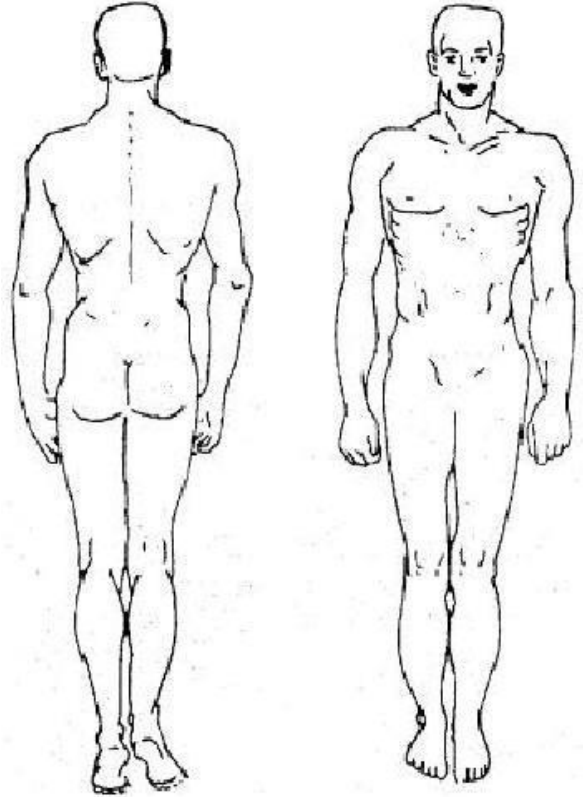
How did you hear about our clinic? _____

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

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 paying the posted service fees in full at the time the services are rendered. I consent to an initial examination.

Signature: _____

Date: _____

Dr. Sean Lisk, B.Sc.H., D.C.
Chiropractor
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