

# ARTHUR CHIROPRACTIC DR. SEAN LISK, D.C.

148 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: \_\_\_\_\_  
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: \_\_\_\_\_

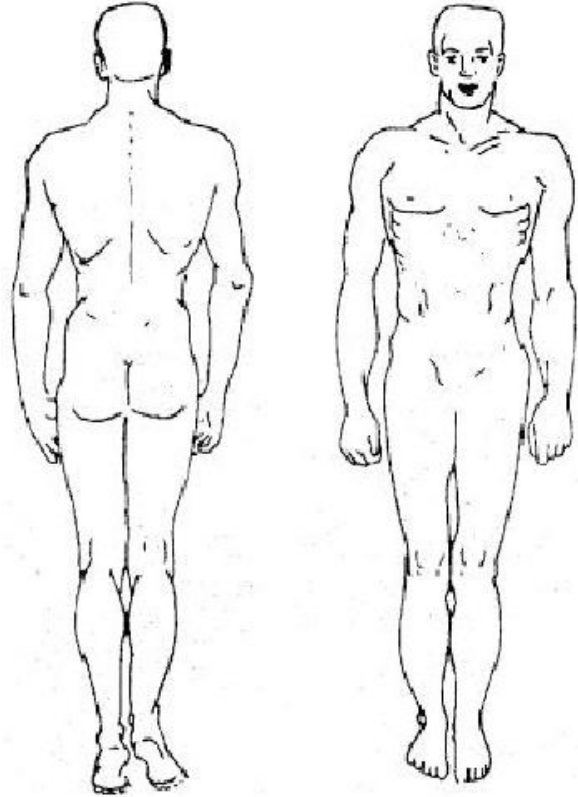
How did you hear about our clinic? \_\_\_\_\_

**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**  
**TEL: (519) 848-2451**

**PATIENT NAME**

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**148 GEORGE ST.**  
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