Arthur Chiropractic
Dr. Sean Lisk, D.C.

148 George St. Tel: (519) 848-2451
Arthur, ON, N0G 1A0

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: _____

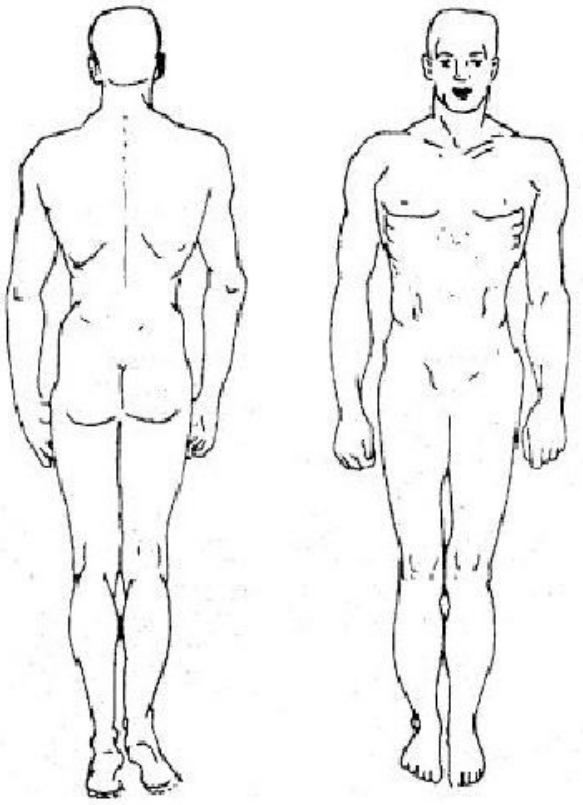
How did you hear about our clinic?_____

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

_____

ARTHUR CHIROPRACTIC
148 GEORGE ST.
ARTHUR, ON
N0G 1A0

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Chiropractor
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Patient Name

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