13- 1399 Mcphillips Street
Winnipeg, MB R2V 3C4
Phone no: 204 942 4476

How did you hear about us?

PATIENT INFORMATION

Patient's Name	Gender: ❑ Male ❑ Female	Date of Birth: (DD/MM/YYYY)
		Age:
Street Address:		
City/Province:	Postal Code:	
Home Phone:	Cell Phone *(for reminders)*:	
Email *(for reciepts/reminders)*:		Occupation:

INSURANCE INFORMATION

Do you have any private Insurance? (Blue Cross, GWL, Sunlife ETC.)

Is this a Workers Compensation or an Autopac claim?		If "Yes"
	Claim no:	Date of Accident:

Have you been to a Chiropractor before?
If "Yes" How many visits this year?

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone no:

DIRECT BILLING

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for claims.

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize to disclose and release protected health information in the form of chiropractic and X-Ray reports to the family doctor or physican in your care. I understand that, I may refuse to sign this authorization and that it is strictly voluntary.

Name of Family Doctor/Clinic:	Phone no:

PRIVACY NOTICE

Please review RCWIC notice of privacy practice. Your name and signature on this intake form indicates that you have reviewed a copy of our clinic's privacy notice on the indicated date.

I have read the above and I acknowledge to the best of my knowledge that this information is accurate and true.

Signature: Date:

please see next page

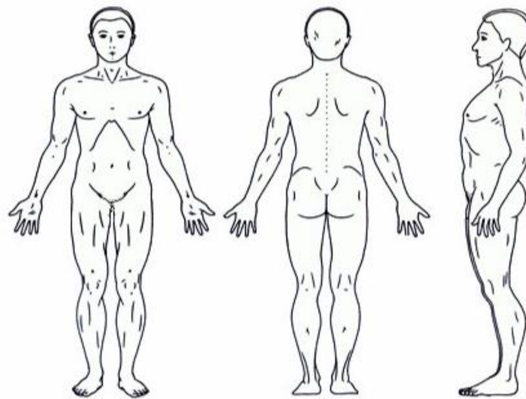
QUESTIONNAIRE

Have you ever had the following? Circle Yes or No

A history of cancer	Yes	No
Unexplained weight loss	Yes	No
Night pain, unrelated to movement	Yes	No
Severe fever or chills	Yes	No
New unexplained skin lesions	Yes	No
A recent bacterial infection	Yes	No
Osteoporosis	Yes	No
Numbness or weakness in arms/legs	Yes	No
High blood pressure	Yes	No
Heart attack/disease	Yes	No
Stroke	Yes	No
High cholesterol	Yes	No
Diabetes	Yes	No
Nausea /Dizziness	Yes	No
Abdominal pain	Yes	No
Difficulty with urination	Yes	No
Blood in stool/ urine	Yes	No

PAIN DIAGRAM

Please circle on the body diagram where you are experiencing the pain/symptoms.



Current pain/discomfort level

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Do you have any health conditions?

Past hospitalization?

Past surgeries?

I have read the above and I acknowledge to the best of my knowledge that this information is accurate and true.

Signature: **Date:**