

Palmerston Chiropractic, Naturopathic & Massage Therapy
336 Main St. W., Box 760, Palmerston, Ont. N0G 2P0
Phone: (519) 343-2264 Fax: (519) 343-4693
pcnmt@wightman.ca

Doctor: _____ (Filled in by office)

PATIENT ENTRANCE FORM

Last Name _____ First Name _____ Middle Name _____
Address _____ Fire # _____ P.O. Box# _____
Town/City _____ Postal Code _____
Home Phone# _____ Cell# _____ Email _____
Date of Birth (D/M/Y) _____ Age _____ Male/Female _____ Marital Status _____
Occupation _____ Employer _____
Address _____ Phone# _____
Spouse's Name _____ Children's Names _____

Parent/Guardian (if a child or student) _____

Extended Health Care Policy # and Co. _____

Who referred you to our office? _____

ARE YOU HERE DUE TO A RECENT

- | | | | |
|----------------------------|-----|----|-----------------------------|
| 1. Motor vehicle accident? | Yes | No | (if yes, ask for MVA Form) |
| 2. Work related injury? | Yes | No | (if yes, ask for WSIB Form) |

PRIOR CHIROPRACTIC &/ OR NATUROPATHIC CARE

Name _____ Address _____
Treated for _____ Last Visit _____
X-rays Taken Yes No Approximate Date _____

MEDICAL DOCTOR

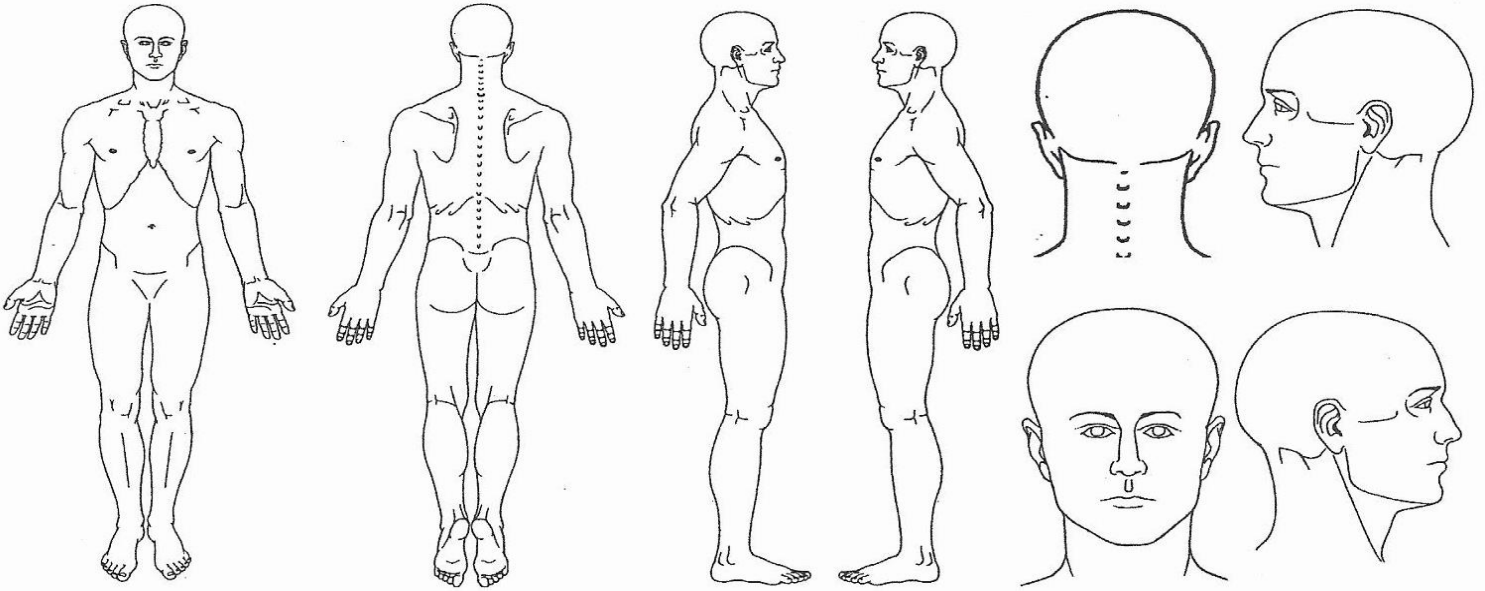
Name _____ Phone # _____ Fax# _____

Address _____

Approximate Date of Last Visit _____ Approximate Date of Last Physical _____

REASON FOR CONSULTING THIS OFFICE

Please mark areas of pain or symptoms on the diagrams. Include all affected areas.



Please list surgeries and significant past illnesses, include approximate dates.

Please list significant past injuries and accidents (e.g., auto accidents), include approximate dates.

Please list current medications, supplements, remedies etc. (We can also photocopy your list if available).

Please list any known or suspected allergies (sensitivities).

Patient's Signature _____ Date _____

Parent /Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____