



2 Marsellus Dr. #15  
Barrie, ON  
L4N 0Y4

Tel/FAX: (705) 728 9999  
info@hmchiropractic.ca  
hmchiropractic.ca

**Rates of Service**

Initial visit, with or without treatment: \$120.00  
Subsequent visit with treatment: \$60.00  
Extended visit with treatment \$85.00  
Custom Orthotics: \$450 +

**Patient Information**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone#: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
May we have your permission to contact you via Email? (circle one): YES NO  
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 with regards to your chiropractic care? (circle one): YES NO

List any current medications: \_\_\_\_\_  
List any past surgeries and dates: \_\_\_\_\_  
List any past 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: \_\_\_\_\_

**FEMALES:** Is there any possibility of you being pregnant? \_\_\_\_\_

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

Dr. Jennifer Malowney, BSc, DC  
Dr. Scott Best, BA, DC  
Chiropractors  
Tel/Fax: 705 728 9999

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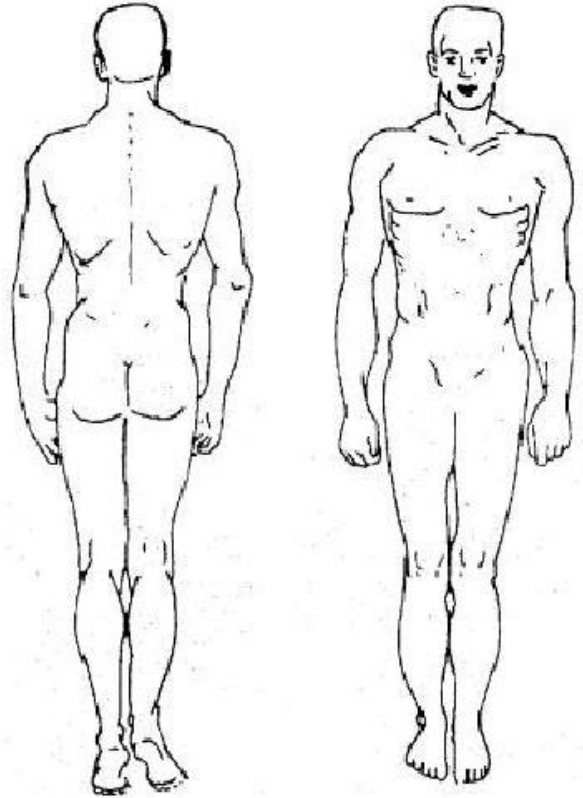
\_\_\_\_\_

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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