995 Front Road
LaSalle, ON N9J 2A5
Ph. 519-978-3305 Fx. 519-978-2290
Dr. James Wawrow & Dr. Angelo Cerchie

PATIENT INTAKE FORM

Name: _____ **Date:** _____

Address: _____ **City:** _____

Province: ____ **Postal Code:** _____ **Ph. #1** _____ **Ph #2** _____

E Mail Address: _____

D.O.B (D/M/Y) _____ _____ _____ **Age:** _____ **Marital Status: S M D W S**

Occupation: _____ **Employer:** _____

Address: _____

Closest Relative: _____ **Ph.** _____

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Extended Health Care Company : _____

Policy Number: _____

How Did You Hear About This Office?

_____ **Website** _____ **Yellow Pages** _____ **Friend** _____
_____ **Newspaper Ad** _____**Other** _____

Prior Chiropractic Care:

Name of Dr. or Clinic _____ **Date of Last Visit:** _____

X-Rays Taken: __ YES __ NO **Results: EXCELLENT GOOD FAIR POOR**

Medical Care:

Name of Doctor: _____ **Date of Last Visit:** _____

Would you be interested in seeing our Naturopath Dr. Elizabeth Yaworsky? YES _____
We offer FREE 15min consultations and discounts for your initial visit!

Reason for consulting this office: _____
_____
_____

Expectations: _____

Have you ever had any of the following:

___ Aneurysm	**___ Osteoporosis**	**___ Diabetes**	**___ Cancer**
___ Stroke	**___ Hepatitis**	**___ Epilepsy**	**___ Sinus Issues**
___ Respiratory Conditions	**___ Nerves**	**___ Asthma**	**___ Fatigue**
___ Psoriasis	**___ Arthritis**	**___ Sleeping Difficulty**	**___ Pleurisy**
___ HIV	**___ Polio**	**___ Allergies _____**	
___ Pneumonia	**___ Heart Conditions_____**		

<u>Smoking History:</u>
Do you smoke cigarettes? _____ How many per day? _____
Do you have any desire to quit? _____

Childhood Conditions, please check

__ Measles	**__ Mumps**	**__ Chicken Pox**	**__ Whooping Cough**
__ Scarlet Fever	**__ Diphtheria**	**__ Rheumatic Fever**	**__ Typhoid Fever**
__ Tubes in Ears	**__ Ear Infection**	**__ Chronic Illness, please explain_____**	

_____