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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. _____

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:

<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sinus Issues
<input type="checkbox"/> Respiratory Conditions	<input type="checkbox"/> Nerves	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sleeping Difficulty	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> HIV	<input type="checkbox"/> Polio	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Conditions	_____	_____

Smoking History:

Do you smoke cigarettes? _____ How many per day? _____

Do you have any desire to quit? _____

Childhood Conditions, please check

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Tubes in Ears	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Chronic Illness, please explain	_____
