

# PATIENT INFORMATION

Dr. T.J. McKay, D.C.  
Dr. K.B. Jenkins, D.C.

Date \_\_\_\_\_

Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Business phone \_\_\_\_\_ Postal Code \_\_\_\_\_

Occupation or Profession \_\_\_\_\_ Date of Birth \_\_\_\_D\_\_\_\_M\_\_\_\_Y

Marital Status S M W D Common-law Spouses name \_\_\_\_\_

Previous Chiropractic Care Y\_\_ N\_\_ By Whom \_\_\_\_\_ Last Seen \_\_\_\_\_

Medical Practitioner \_\_\_\_\_ Last Seen \_\_\_\_\_

Alberta Health Care Number: / / / / / / / / / / / / / / / /

Do you have Private Health Insurance? Y\_\_ N\_\_ Name of Company \_\_\_\_\_

Who your referred you to this office? \_\_\_\_\_

Have you ever had any falls, accidents, or injuries? Y\_\_ N\_\_ If yes, please explain \_\_\_\_\_

Have you ever had surgery? Y\_\_ N\_\_ If yes, please explain and give dates \_\_\_\_\_

Medication presently taking \_\_\_\_\_

Purpose of visit / primary complaints \_\_\_\_\_

Do you have any health problems that you think chiropractic cannot help? \_\_\_\_\_

I clearly understand and agree that all services rendered to me, that are not covered by Alberta health care or WCB, are charged directly to my account, and that I am responsible for payment of services as they are performed.

Signed \_\_\_\_\_