RE-EXAM FORM

HARMONY
CHIROPRACTIC

Full Name: _____ Gender: _____
Date of Birth (MM/DD/YYYY): _____
Address: _____ Postal Code: _____
City/Province: _____ Phone Number: (Home) _____
(Work) _____ (Cell) _____
Email: _____ Occupation: _____
Employer & Address: _____
Emergency Contact: _____ Relation: _____ Phone: _____

Are you claiming for an accident under: **MPI / WCB**
Claim Number: _____
Date of Accident: _____
Have you ever had a MPI or WCB claim in the past? **Yes / No**
Please list your reason for seeking care out at HC, and describe the accident (if applicable):

_____

_____

_____

What other treatment have you had for this condition: _____
Have you missed work or school beacuse of this condition? **Yes / No**
Are you currently working? **Yes / No** Are you performing modified duties? **Yes / No**

It is getting: **Better / Worse / Not Changing**
This interferes with: **Work / Sleep / Exercise / Daily Activity / Other**
On a scale from 0 (no pain) to 10 (worst pain imaginable), please rate your discomfort:

0 1 2 3 4 5 6 7 8 9 10

Are there any changes to your health history? _____

_____

The personal health information you provide us will be kept confidential and secure and only used by the practitioners and staff at Harmony Chiropractic. However, limited information, such as date of service, may be requested and collected on occasion by your insurance provider. I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, and that if I suspend or terminate my care, any outstanding charges for services rendered to me will be immediately due.

Name: _____

Signature of patient/guardian: _____ Date: _____