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: _____
Emergency Contact: _____ Relation: _____ Phone: _____

Are there any changes to your health history? _____

_____

Please list your reason for returning to Harmony Chiropractic, or describe the accident (if applicable):

_____

_____

What other treatment have you had for this condition: _____
Have you missed work or school because 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: _____

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

The insurance and personal information you provide us will be kept confidential and secure and only used by 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 and consent to release of this information as necessary.

Harmony Chiropractic offers the service of direct billing to its patients and clients. If direct billing is not available, or no coverage exists or remains for the services rendered, outstanding fees will be charged directly to the patient. I understand and agree that I am personally responsible for this payment, and that any outstanding charges for services rendered to me will be immediately due.

Name: _____

Signature of patient/guardian: _____ Date: _____