Welcome to the King City Natural Health Centre

We welcome you and look forward to the opportunity of serving your health needs. Please read the following so you understand our clinic procedures and policies.

1. Please fill out any intake/health history forms as completely as possible.
2. The majority of our patients will complete an on-line health assessment for a complete health/medical history. Separate instructions will be provided for this assessment.
3. Please arrive on time, or before your scheduled appointments. If there are any special instructions, or specific need for you to arrive ahead of time, our staff will inform you.
4. Appointment changes should be made 24 hours/one business day in advance. This allows us time to schedule someone else in need. We reserve the right to charge a missed appointment fee, equal to the amount of the missed appointment or service.
5. Fees for services, assessments and items dispensed are due in full at the time of service. Payments can be made by cash, personal cheque, VISA, MasterCard and debit.
6. If your insurance company covers the service provided, fees are to be paid at the time of service and we will provide the necessary statements. We will also fill out any insurance forms for you to submit to be reimbursed.
7. Phone consultations in lieu of appointments will be charged at the appointment rate.
8. It through the course of your care, you feel that your needs have not been heard or handled with consideration and efficiency, or you feel there are other ways we can enhance your care, we encourage and welcome your constructive feedback.

Thank you for choosing our clinic as part of your health team.

I have read and understand the information and policies stated above.

Signed______________________________Date_____________________

Welcome

It is our pleasure to welcome you to the King City Natural Health Center. To help us serve you better, please complete the following information. Please note, there are two pages to this form. We look forward to working with you to build better health for you and your family.

Name:____________________________________Date:______________________.
Address:_________________________________City:_______________________.
Postal Code:______________Email:______________________________________.
Home phone: ______________________Work phone: _______________________
Birth date:_____________________Occupation:______________________________.

Whom may we thank for referring you? ___________________________________.

What is the **main** reason for consulting our office today?____________________,
____.
Has this problem occurred before? **Y or N** If so, when? ____________________.

List, **in order of importance**, any other health challenges that concern you:
1)____.
2)____.

Do any of these conditions interfere with (**please circle**):
Sleep Daily activities Exercise Walking Sitting Lifting

Does anything make it feel better? **Please list:**______________________________.

Previous chiropractic experience? **Y or N**
Name of chiropractor_____________________________ Date of last adjustment_________

List all falls, accidents or injuries you have had and give approximate dates:
____
____
____

Have you ever been hospitalized? **Y or N** If yes, when?____________________________
Have you ever had x-rays done? **Y or N** If yes when?_____________________________

Please list any current medications:____
How many hours of sleep do you get per night?___________________________________
How would you describe your quality of sleep? Scale of 1-10:____________________

How would you describe your nutritional intake? Excellent ☐ Good ☐ Fair ☐ Poor ☐
…your physical health? Excellent ☐ Good ☐ Fair ☐ Working on it ☐

Do you participate in exercise?___________How often? ________________________

Which of the following do you use **(How much? How often? For how long?)**
Vitamins or Supplements:____
Caffeine: ________________ Tobacco: ________________ Alcohol: _______________

Do you work with any chemical, fume, dust, powder, vibration or smoke for prolonged periods of time? **Y or N**
If yes, please describe: ____

Occupational stress (1-10 with 10 being **most** stressful):___________________________

Do you have children? **Y or N**
If so, please list names and ages: ____
Please list any health concerns of children: _____________________________________

Please describe the health status of your mother: ________________________________
Please describe the health status of your father: _________________________________

Please **circle** any of the following that are affecting your health:

Gas or bloating after meals	visual problems	forgetfulness
Constipation	earaches	nervousness
Diarrhea	fatigue	numbness
Nausea	loss of sleep	shortness of breath
Excessive thirst	allergies	sinus problems
Poor/excessive appetite	irregular heartbeat	headaches
Weight challenges	dizziness	asthma

Females: Do you suffer from menstrual (please **circle**)**:** cramping irregularity pain
Date of last period: _________________ Are you pregnant? Yes ☐ No ☐ Maybe ☐

I understand that my personal information will be kept confidential in accordance with The Registered Health Practitioners' Act and Privacy Legislation. I also understand and consent to a chiropractic/physical/x-ray examination to determine the nature of my condition and for **Dr. Timothy Houlton** to determine if his care is appropriate for my condition.

Name: ___________________ Signed: ________________________ Date: ________