K A I Z E N | H E A L T H

ENTRANCE FORM

Name:________________________________Date:__________________________

Address:____

City, Province:____________________________Postal Code:________________

Home phone:____________________ Business phone:_____________________

Date of Birth (D/M/Y): ________________ Age: ____________

Occupation:____

Employer:____

Address:____

Closest Relative/Spouse:____

Phone:______________________________

Provincial Health Card Number:________________Letter Code:_____________

How did you hear about our office: friend ☐ phone book ☐

Other: ____

Reason for consulting this office: _______________________________________

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KAIZEN | HEALTH

Please check the services that you are interested in:

- ☐ Chiropractic Care
- ☐ Massage Therapy
- ☐ Nutritional Counselling/Biosignature Evaluation
- ☐ Exercise/Rehab

PRIOR CHIROPRACTIC CARE:

Name of Chiropractor:___________________________

Telephone:___________________________

X-rays taken: Yes No

Date:_____________________________

Date of Last Chiropractic Treatment:_____________________________

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name:_______________________________

Telephone:____________________________

Address:____

Date of Last Appointment:__________Date of Last Physical:____________