KAIZEN | HEALTH

ENTRANCE FORM

Name: _____Date:_____

Address: _____

City, Province:_____Postal Code:_____

Home phone:_____ Business phone:_____

Date of Birth (D/M/Y): _____ Age: _____

Occupation:_____

Employer:_____

Address:_____

Email: _____

Emergency Contact: _____

Contact Number:_____

How did you hear about our office?

_____

Reason for consulting this office: _____
_____
_____
_____
_____

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Please check the services that you are interested in:

- ☐ Chiropractic Care
- ☐ Acupuncture
- ☐ Nutritional Counseling/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:_____