BELL CHIROPRACTIC
26 COLBORNE STREET EAST, ORILLIA ONTARIO

PATIENT INFORMATION UPDATE

Name: _____ DOB:_____

Address: _____

Phone No.: Home_____ Cell: _____
Business: _____

Area of current injury/symptoms:_____
_____
_____
_____

Work Injury: Yes No

Due to Motor Vehicle Accident: Yes No

Date of Accident or work injury: _____

Change in health status since last visit to Back to Function? Yes No
Details:_____
_____
_____

Tests (x-rays, CT, MRI, diagnostic ultrasound) done for current injury/symptoms:
Test: Date: Where:

- I am aware that Back to Function adheres to a privacy policy according to the Personal Information Protection and Electronic Documentation Act (PIPEDA) Yes No
  (our privacy policy is available at the front desk)

- Consent to collect relevant personal/health information Yes No

_____ _____
Signature Date