

# Welcome to the Advanced Wellness Centre

To serve you better, please take a moment to complete this form. If you require assistance, please let us know. When finished, kindly bring this form to the front desk on your first visit or email it to us at [info@advancedwellness.ca](mailto:info@advancedwellness.ca).

<b>Please Tell us About Yourself:</b>		
Name:		Date of Birth: MM / DD / YYYY
Address:	Suite:	City:
Postal Code:	Male   Female	He   She   They
Email Address:		
Cell Phone:	Home Phone:	Work Phone:
Have you ever been a patient here before?	Yes, When	No
How did you learn/hear about us? If Referred, please name the referral:		
I am looking for: (check all that apply) Acupuncture   Chiropractic   Massage   Naturopathic Medicine   Nutrition   Physical Therapy   Not sure		
Family Doctor Name:	Family Doctor Clinic/Phone:	
Emergency Contact Name:	Emergency Contact Phone Number:	

<b>Please Tell us About Your Primary Health Concern:</b>
What can we help you with? What is your main reason for seeing us? (symptom, problem, pain, issue) Where does it hurt?
How long have you had it? When did it first begin?
How often do you get it?
What have you tried previously to help (reduce, improve, get rid of)?
Please let us know if this pertains to:   Motor Vehicle Accident   Workplace Injury   Lawsuit   None of Those Apply

<b>Insurance Information:</b>				
Do you have any health benefits/insurance that may cover some services here?		Yes	No	Not sure
Employer's Name:				
Insurance Provider:	Policy:	Member:		

<b>Anything Else We Should Know about:</b>
Do you have any other symptom(s) or health concern(s)? If you could change or improve anything else about your health or your body, what would that be?
Where are you feeling any pain, discomfort, or soreness today? Yes, where? <span style="float: right;">No</span>
I am seeing the following health professionals currently or within the last 3 months: Massage Therapist    Chiropractor    Acupuncturist    Physiotherapist    MD    Other:
If we could help improve, reduce, or get rid of some of these or all these problems, would you want our help today? Yes      No      Not sure

<b>Would you like to improve any of the following (Check all that apply)</b>	
Digest food better / not avoid certain foods	Lose weight and keep it off
Eliminate or reduce digestive problems	Recover from a recent injury or accident
Sleep better / have more restful sleep	Have better hormone balance
Have more energy / less fatigue	Handle my stress better
Eliminate or reduce allergies or asthma	Feel less irritable / less mood swings / less anxiety
Eliminate or reduce headaches or migraines	Better balance / flexibility / coordination
Have less muscle tension or soreness	Reduce heavy metals or detoxify better
Have less joint pain or stiffness	Live longer and stay healthy as I age
Eliminate or reduce neck or back pain or tension	Look and feel younger regardless of age
Eliminate or reduce chronic or acute pain	Prevent joint problems like arthritis or back pain
Have less numbness/tingling/burning sensations	Other (please explain):
Help with fertility issues	