Date:___/____/___ (d/mm/yr) Last Name:_____ First name:_____ (On MH Card)
Name I prefer to go by: _____ M ___ F ___ Date of Birth: ____/____/_____(dd/mm/yr)
Address: _____City: _____ Province: ____ Postal Code: _____
Phone Home: _____ Work: _____ Cell: _____ Email: _____
Occupation: _____ Employer: _____
Marital Status: ___ single ___married ___common law Spouse's name: _____
MB Health Number (6 digits): _____ PHIN (9 digits):_____

Who can we thank for referring you to our office? _____
Have you received chiropractic care before? Y N How long ago? ____Were you pleased with your care? Y N
Are you claiming under Worker`s Compensation? Y N Claim # _____Date of injury: _____
Are you claiming under Manitoba Public Insurance? Y N Claim # _____ Date of MVA: _____

What is your primary reason and/or health concern for your visit today? _____
When did this concern begin?_____ Has it occurred before? Y N Is it getting worse? Y N
What makes it worse? _____ What makes it better? _____
How is this concern AFFECTING your QUALITY OF LIFE? _____
Have you sought help from other health practitioners for your above health concern? Y N
If yes, please, explain: _____
Is there a possibility that you are pregnant? Y N

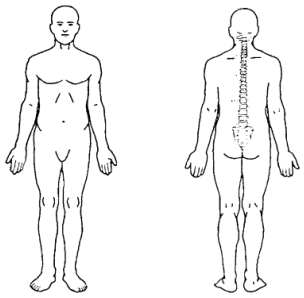
Do you suffer from:

- ❒ Headaches
- ❒ Migraines
- ❒ Dizziness
- ❒ Fainting
- ❒ Loss of Balance
- ❒ Loss of Memory
- ❒ Buzzing in Ears
- ❒ Ear Infection
- ❒ Other _____
- ❒ Allergies
- ❒ Sinus Problems
- ❒ Fever
- ❒ Frequent Colds/Flu
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Diarrhea
- ❒ Ulcers
- ❒ Painful Menstruation
- ❒ Arthritis
- ❒ Diabetes
- ❒ Fatigue
- ❒ Sleep Problems
- ❒ Thyroid Problems
- ❒ Asthma
- ❒ Shortness of Breath
- ❒ Cold Feet/Hands
- ❒ Cold Sweats
- ❒ Low/High Blood Pressure
- ❒ Heart Surgery/Pacemaker
- ❒ Pins & Needles/Numbness
- ❒ Depression
- ❒ Irritability
- ❒ High Anxiety

Please check any areas where you feel pain:

- ❒ Neck
- ❒ Mid Back
- ❒ Low Back
- ❒ Chest
- ❒ Shoulder
- ❒ Elbow
- ❒ Other _____
- ❒ Hip
- ❒ Knee
- ❒ Ankle
- ❒ Foot
- ❒ Wrist
- ❒ Hand

Please mark any area of pain on the figures:



Do you take any medication? Y N Which one(s) & for how long?_____
Do you take any over-the-counter medication (including pain relievers)? Y N How often_____
Have you had surgery? Y N When? _____ Please explain: _____
Have you been involved in a car accident or any other major fall or trauma? Y N When? _____
Please explain: _____
Family history of: ❒ Heart Disease ❒ Arthritis ❒ Cancer ❒ Diabetes ❒ Other _____

People seek chiropractic care for a variety of reasons, some for pain relief, some to correct the cause of pain and others for optimal health. Your doctor will weigh your needs when recommending your program of care. Please check the boxes that most closely describes your current goals for health/well-being:

- ❒ *I am mainly concerned about relief of a particular symptom*
- ❒ *I am mainly concerned about relief of a symptom and preventing its return*
- ❒ *I want optimum health and well-being on every level available to me*