Full Name _____
Address _____
City _____ Prov _____ PC _____
Phone: (C) _____ (W) _____
Email: _____
Date of Birth: _____ Age: _____

Occupation: _____
Marital Status: S M D W
Spouse's Name: _____
No. of children: _____
Referred By: _____
MB Health Registration No. (6-digit): _____
MB Health P.H.I.N. (9-digit): _____

Chiropractic History

Have you previously seen a chiropractor? ☐Yes ☐No Reason: _____
Did they take x-rays? ☐Yes ☐No If yes, when was your last visit? _____

Current Health Condition ☐ I'm here for wellness and have no complaints (please skip to the next section).

Have you previously seen a chiropractor? Yes No Reason: _____
Did they take x-rays? Yes No If yes, when was your last visit? _____
Reason for today's visit: _____
_____
When did the pain/problem start? _____ Why do you think the pain started? _____
_____
Pain is: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Feels like _____
Pain/Problem interferes with: ☐Work ☐Sleep ☐Routine ☐Other _____
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is it worse during certain times of the day? _____
Is this condition getting progressively worse? ☐ Yes ☐ No
Other Doctors Seen: _____

Other Symptoms: *(please check all that apply)*

☐ Headaches	☐ Pins & Needles in Legs	☐ Ears Ring/Buzzing	☐ Stomach Upset	☐ Anxiety
☐ Neck Pain/Stiffness	☐ Pins & Needles in Arms	☐ Fever	☐ Nausea	☐ Multiple Sclerosis
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Fainting	☐ Constipation	☐ Blood Clots
☐ Back Pain	☐ Numbness in Toes	☐ Cold Sweats	☐ Loss of Balance	☐ Other conditions, diseases or concerns:
☐ Nervousness	☐ Shortness of Breath	☐ Loss of Smell	☐ Ear Infections	_____
☐ Tension	☐ Fatigue	☐ Loss of Taste	☐ Asthma	_____
☐ Irritability	☐ Depression	☐ Difficulty Swallowing	☐ Allergies	_____
☐ Chest Pains	☐ Light Bothers Eyes	☐ Diarrhea	☐ Frequent colds/flu	_____
☐ Dizziness	☐ Double Vision	☐ Cold Feet	☐ Menstrual Problems	_____
☐ Face Flushed	☐ Loss of Memory	☐ Cold Hands	☐ IBS/Crohn's Disease	_____

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate Dates: _____
Any work, sports or other injuries: _____
Any medications you are currently taking: _____
Have you had surgery? ☐ Yes ☐ No What type? _____
When? _____
Any significant family medical conditions/history: _____
_____
Give a brief description of the physical nature of your work or daily routine: _____
_____
Rate your occupational stress (1-10, 10 being most stressful) : _____ Rate your family/life stress (1-10): _____
Do you smoke? ☐Yes ☐No How many per day? _____ Do you drink alcohol? ☐Yes ☐No How many per week?_____

As a result of my chiropractic care, I would like to: (please check all that apply)

☐Feel better quickly
☐Have a healthier spine & better postural alignment
☐Improved function & performance
☐Have a better quality of life

Signature _____ Date _____

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