OSBORNE CHIROPRACTIC OFFICE
REHABILITATION & WELLNESS CENTRE

757 Osborne Street. Winnipeg, MB R3L 2C4
Phone: (204) 475-9188 Fax: (204) 284-5017

CHIROPRACTIC INTAKE & HISTORY

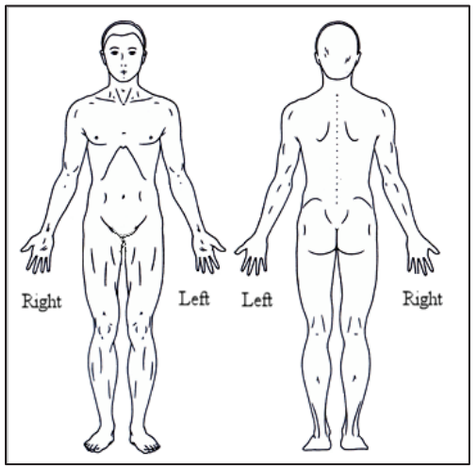
PATIENT INFORMATION		
Manitoba Health Card Number:	9 Digit:	6 Digit:
Last Name:	First Name:	Date:
Date Of Birth: (dd/mm/yyyy)	Gender: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W
Address:		City/Prov:
Postal Code:		
Phone (H):	Phone (W):	Phone (C):
Email Address:		Referred by:
Spouses Name:		
Occupation:		
Have you seen a chiropractor before? ☐ Yes ☐ No		If yes, when was your last visit?

HOW CAN WE HELP YOU?

What brings you in today?_____
If you are already experiencing a symptom, what is it?_____
Is this visit due to a ☐motor vehicle accident or ☐work injury?_____

How intense are your symptoms?
Occasional Pain Very Intense
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please circle areas to the right where you have pain or other Symptoms:



What Does it feel like?

☐Numbness ☐Sharp
☐Dull ☐Radiating
☐Tingling ☐Shooting
☐Stiffness ☐Burning
☐Aching ☐Stabbing
☐Cramping ☐Swelling
☐Nagging ☐Other_____

IMPACT OF YOUR SYMPTOMS

How are the symptoms/condition interfering with your life? (check where appropriate)

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____				

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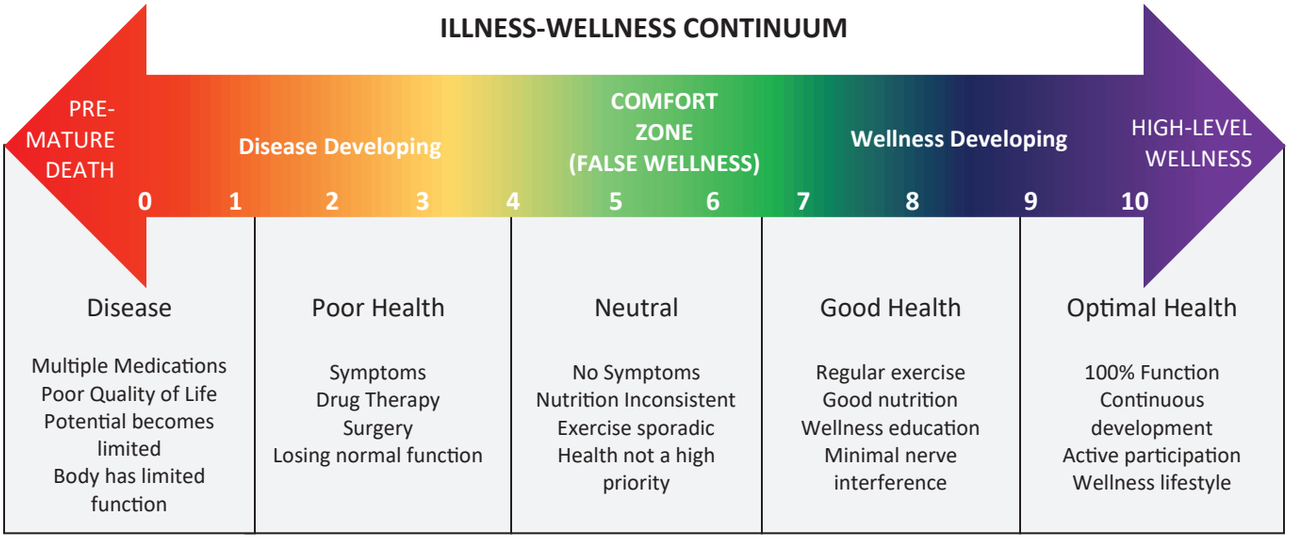
PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today?_____

B. In what direction is your health currently headed?_____

What are your health goals?

IMMEDIATE_____

SHORT TERM_____

LONG TERM_____

HEALTH & ILLNESS HISTORY (Please check the box beside any condition that you have or have had)

☐Headache/Migraines	☐Arthritis/Joint Problems	☐Sinus Problems/ Allergies	☐High Blood Pressure
☐Neck Stiffness/Pain	☐Fatigue	☐Shortness of Breath	☐Dizziness/ Vertigo
☐Heart Problems/ Stroke	☐Shoulder Stiffness/Pain	☐Constipation/ Diarrhea	☐Cancer
☐Pins & Needles in Arms	☐Tension/ Stress	☐Numbness in Fingers	☐Nervousness/ Anxiety
☐Cold Sweats	☐Recurring infection	☐ Back Stiffness/Pain	☐Hot Flashes
☐Loss of taste/smell	☐Irritability/ Mood Swings	☐Numbness in Feet/Toes	☐Upset Stomach
☐PMS	☐Buzzing/ Ringing in Ears	☐Jaw/TMJ Problems	☐Ulcers
☐Cold Hands/ Feet	☐Chest Pains	☐Other_____	

CHILDREN & PREGNANCY

Are you or might you be pregnant? ☐No ☐Yes, I am due_____

Name_____Age_____Health Concern_____

Name_____Age_____Heath Concern_____

Name_____Age_____Health Concern_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS	SUPPLEMENTS

The above stated is true. I clearly understand and agree that all services rendered to me that are not covered by Manitoba Health, WCB, MPI, Private Insurance and Co-payments are charged directly to my account and that I am responsible for any outstanding fees.

Signature_____ **Date**_____