

105-20 PTH 52W Steinbach MB, R5G 2L2 Phone: (204) 326-2005 Fax (204) 326-1901

CHIROPRACTIC INTAKE & HISTORY

PATIENT IN	FORMATI	ON								
Manitoba Health Card Number:				9 Digit:			6 Digit:	6 Digit:		
Last Name:				First Name:			Date:			
Date Of Birt	th: (dd/n	nm/yyyy	/)	Gender:	□ M □ F		Marital Sta	tus: 🗆 S 🗆	$M \; \square \; D \; \square \; W$	
Address:			1				City/Prov:			
Postal Code	2:									
Phone (H):				Phone (W):			Phone (C):			
Email Address:								Referred by:		
Spouses Na	me:									
Occupation	:									
Have you seen a Chiropractor before? ☐ Yes ☐ N					No	If yes, when was your last visit?			visit?	
ou are alread this visit due t w intense are casional Pain 1 □2	to a □mo e your sym	tor vehi	cle accident (ury?	Very Ir □10			_	
ease circle are mptoms: hat Does it fe				e pain or othe	er		(F)			
Numbness Dull Tingling Stiffness		□Shar □Radi □Shoo □Burr □Stab	ating oting ning bing				Right	Left Left	Right	
Aching Cramping Nagging		□Swe □Othe	lling er					Carrie Carrie	214	
Cramping Nagging IPACT OF YC	mptoms/c	Othe	er i interfering v		? (check where a					
Cramping Nagging IPACT OF YO		PTOMS ondition Mild	interfering v	Severe	1	None I	Mild Mode	erate Severe		
Cramping Nagging IPACT OF YC w are the syr	mptoms/co None	PTOMS ondition Mild	interfering v	Severe	Energy	None I	Mild Mode			
Cramping Nagging PACT OF YC w are the syr ork ercise	nptoms/co	PTOMS ondition Mild	interfering was Moderate	Severe	I Energy Attitude	None I	Mild Mode			
Cramping Nagging PACT OF YC w are the syr ork ercise creation	mptoms/co	PTOMS ondition Mild	interfering v Moderate	Severe	Energy Attitude Patience	None I	Mild Mode			
Cramping Nagging PACT OF YC w are the syr ork ercise	nptoms/co	PTOMS ondition Mild	interfering was Moderate	Severe	I Energy Attitude	None I	Mild Mode			



Signature

105-20 PTH 52W Steinbach MB, R5G 2L2 Phone: (204) 326-2005 Fax (204) 326-1901

PATIENT WELLNESS ASSESSMENT ILLNESS-WELLNESS CONTINUUM **COMFORT** PRE-HIGH-LEVEL ZONE **MATURE Wellness Developing Disease Developing WELLNESS** (FALSE WELLNESS) **DEATH** 10 **Optimal Health** Disease Poor Health Neutral **Good Health Multiple Medications Symptoms** No Symptoms Regular exercise 100% Function Poor Quality of Life **Nutrition Inconsistent Drug Therapy** Good nutrition Continuous Potential becomes Surgery Exercise sporadic Wellness education development limited Losing normal function Health not a high Minimal nerve Active participation Body has limited priority interference Wellness lifestyle function 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 \square 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______ _Age____Health Concern____ Name 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.

Date