

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: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____

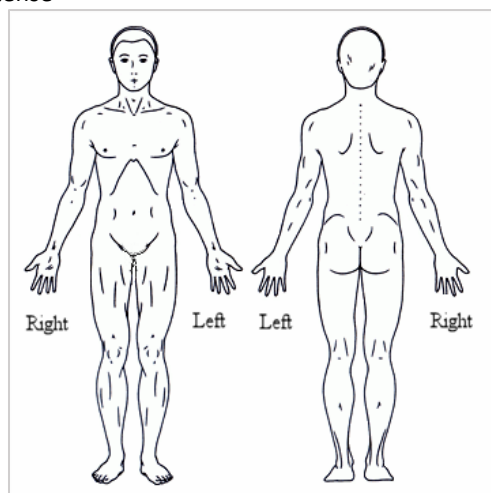
How intense are your symptoms?

Occasional Pain 1 2 3 4 5 6 7 8 9 10 Very Intense

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

What Does it feel like?

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Nagging | <input type="checkbox"/> Other _____ |



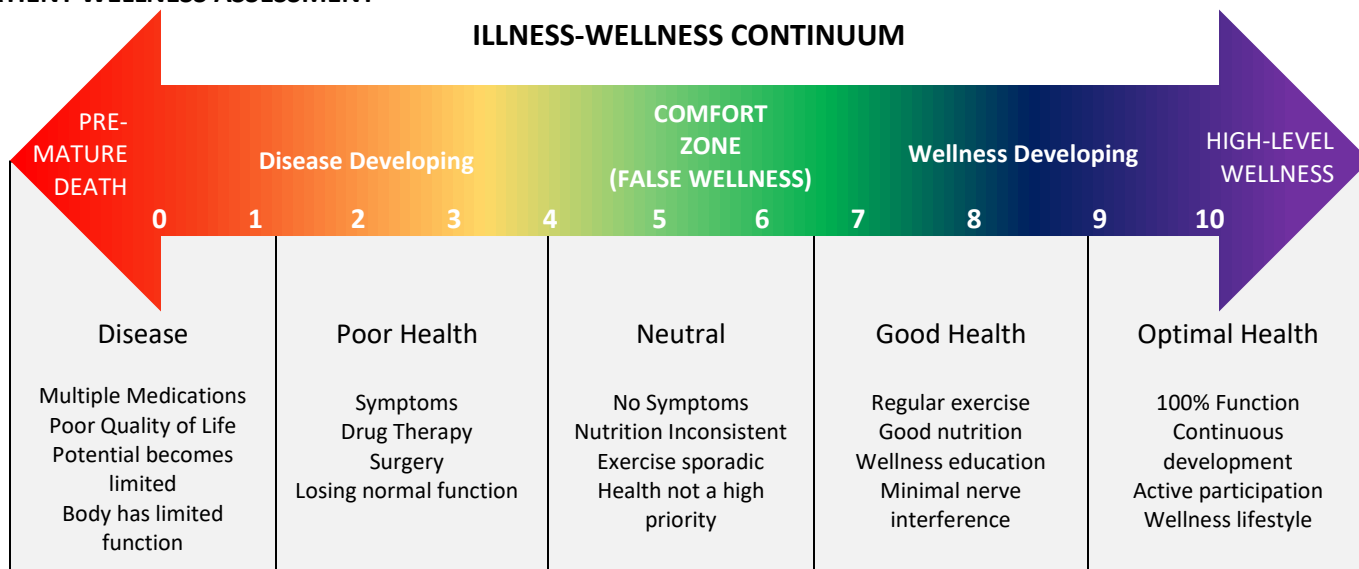
IMPACT OF YOUR SYMPTOMS

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

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____				

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)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Arthritis/Joint Problems | <input type="checkbox"/> Sinus Problems/ Allergies | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Neck Stiffness/Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness/ Vertigo |
| <input type="checkbox"/> Heart Problems/ Stroke | <input type="checkbox"/> Shoulder Stiffness/Pain | <input type="checkbox"/> Constipation/ Diarrhea | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> Tension/ Stress | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness/ Anxiety |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Recurring infection | <input type="checkbox"/> Back Stiffness/Pain | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Irritability/ Mood Swings | <input type="checkbox"/> Numbness in Feet/Toes | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Buzzing/ Ringing in Ears | <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Hands/ Feet | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Other _____ | |

CHILDREN & PREGNANCY

Are you or might you be pregnant? No Yes, I am due _____
 Name _____ Age _____ Health Concern _____
 Name _____ Age _____ Health 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 _____