ACTIVE
CHIROPRACTIC & WELLNESS

Patient Information: Please fill in information as it appears on your Manitoba Health Card

Legal Name: _____ Preferred Name: _____

Name of Parents (if you are under 18): _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Sex: ☐ Male ☐ Female Age: _____ D.O.B: (dd/mm/yyyy)_____

Email: _____

Home Phone #: _____ Occupation/Grade: _____

Work Phone #: _____ Employer/School: _____

Cell Phone #: _____

P.H.I.N #: _____ **6 Digit Medical #:** _____

Whom may we thank for referring you? _____

Accident Information:

Is condition due to an accident? Y / N Date _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Ins. ☐ Employer ☐ Worker Comp. ☐ Other

Claim #: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Home/Cell #: _____

Work #: _____

Patient Condition:

Reason for visit _____

When did your symptom(s) appear? _____

What were you doing when you first noticed the symptom(s)? _____

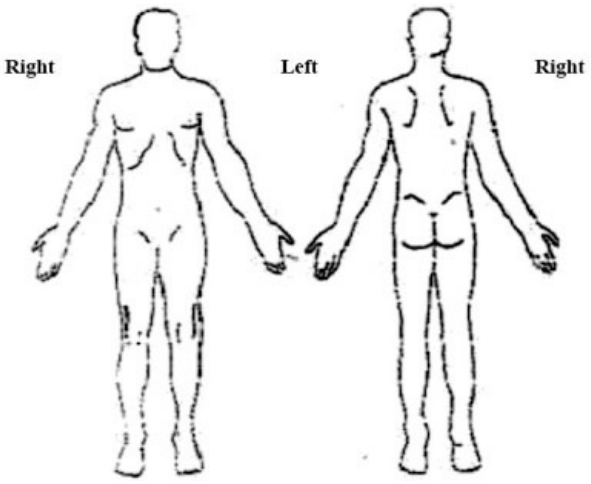
Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from:

0 (no pain) to 10 (severe pain): _____

Mark an **X** on the diagram where you have symptoms:



Type of pain: ☐ Sharp ☐ Dull ☐ Stiffness
☐ Aching ☐ Shooting ☐ Cramping
☐ Burning ☐ Tingling ☐ Throbbing
☐ Numbness ☐ Swelling ☐ Other

How often do you have this pain?

☐ Constant
☐ Intermittent

Does it interfere with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/ Movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

Is there anything else that makes it feel worse? _____

_____

Is there anything that makes it feel better? _____

Have you ever had the same or similar problem before? ☐ Yes ☐ No When? _____

What treatments have you already received for your condition?

☐ Medications ☐ Massage ☐ Physiotherapy ☐ Chiropractic ☐ None ☐ Other _____

Name and Address of other doctor(s) who have treated your condition: _____

Have you had x-rays taken for this condition? ☐ Yes ☐ No

PLEASE SEE OVER

Symptoms Past and Present: Please **CIRCLE** any conditions that are **PRESENT**, and **CHECK** those conditions that were in the **PAST**.

General Symptoms
Loss of consciousness
Depression
Headache
Fever or chills
Night Sweats
Night Pain
Unexplained weight loss
Numbness or tingling
Weakness
Fainting
Dizziness
Allergy
Fatigue
Tremors
Convulsions/Seizures

Skin
Rashes
Lumps
Itching
Dryness
Hair/nail changes

Muscles/Joints
Neck Pain
Mid Back Ache
Low Back Ache
Tailbone
Shoulder Pain
Arm/Forearm Pain
Elbow Pain
Wrist/hand Pain
Hip Pain
Knee Pain
Foot/Ankle Pain
Arthritis
TMJ Pain
Redness/swelling

Urinary
Frequency (changes)
Urgency
Burning or Pain
Blood in Urine
Incontinence
Change in strength

Eyes/Ears/Nose/Throat
Blurry or Double Vision
Earache or Infection
Decreased hearing
Ringing in ears
Recent hoarseness
Swollen glands
Hypo-/Hyper-thyroid

Respiratory
Difficult/painful breathing
Cough
Shortness of breath
Coughing up blood/phlegm
Asthma

GU (WOMEN)
Painful menstruation
Cramping/backache
Hot flashes
Irregular/absent cycle
Excessive Flow

Breasts
Pain, Lumps, Discharge

Cardiovascular
Heart/blood disease
High blood pressure
Shortness of breath with activity
Chest pain or discomfort
Difficulty breathing lying down
Swelling
Stroke
Poor circulation

Gastrointestinal
Recent change in appetite
Nausea/Vomiting
Heartburn
Constipation or Diarrhea
Inflammatory Bowel Disease
Irritable Bowel Syndrome
Ulcer
Gallbladder
Diabetes
Cancer Type: _____
OTHER: _____
OTHER: _____

Family Health Profile:
Please mention below any health conditions (diabetes, cancer, high blood pressure, stroke, etc) associated with your**:**
Parents: _____
Grandparents: _____
Sibling(s): _____
Children: _____
Spouse: _____

Have you had any:	**Description**	**Date**
Falls		
Head Injuries		
Fractures		
Dislocations		
Surgeries		
Car Accident		
Other Trauma		

Please list all:	**Medications**	**Allergies**	**Vitamins/Herbs/Minerals**

Lifestyle:
☐ Smoking Cigs/Day _____
☐ Alcohol Drinks/Week _____
☐ Caffeine Cups/Day _____
☐ High Stress Reason(s) _____

Exercise:
☐ None
☐ Infrequent
☐ Moderate
☐ Daily
☐ Heavy

Work Activity:
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Sleep Nature:
☐ Side
☐ Back
☐ Stomach
☐ Toss+Turn
☐ Trouble Sleeping

Pillow:
☐ Memory Foam
☐ Synthetic Fluff
☐ Water
☐ Feather
☐ Other

NOTE: Payment is expected at time of treatment for any expenses not covered by Medicare, WCB, or MPIC.

Date: _____ **Signature:** _____