Canteenwala Chiropractic

Dr. Sony Canteenwala, D.C.
Dr. Timothy Kowaliszyn, D.C.

Full Name:_____ Date of Birth:_____

Age:_____ Height:_____ Weight:_____

Parent/Guardian's Name (if applicable):_____ Sex: M ☐ F ☐

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Cell/Business Phone:_____ Voice Mail OK? ☐ Y ☐ N

Occupation:_____ Marital Status: ☐ S ☐ M ☐ W ☐ D Number of Children:_____

Spouse's Name:_____Email:_____

Referred By:_____ MHSC 6 digits:_____ 9 digits:_____

***All residents in Manitoba are covered with Manitoba Health for a portion of their first 7 chiropractic adjustments each calendar year.

Have you had Chiropractic care before? ☐ Y ☐ N By Whom:_____ When:_____

For what Reason:_____

Do you have any reason to believe you may be pregnant? ☐ Y ☐ N Due Date:_____

Are you claiming through Autopac (MPI) or Worker's Compensation Board of Manitoba (WCB)? ☐ No ☐ MPI ☐ WCB

Claim Number:_____ Date of Accident:_____

***Important: All Manitoba residents are 100% covered for chiropractic care for all accidents involving a motor vehicle or if they sustain an injury related to work or if an injury occurs in the workplace. All claims are billed directly to MPI or WCB by our office.

WHY THIS FORM IS IMPORTANT:

Our office focuses on maximizing health. Our goals are to 1) address the issue that brought you to this office and 2) offer the opportunity to learn and improve your health potential for the future. Daily activities, stresses and traumas can accumulate and cause damage to your nervous system. This damage builds layer upon layer to a level at which you may not yet be aware. We need to know what your layers of damage contain, so we ask you to carefully fill out this detailed and important form.

Reason for consulting the office:

On a scale of 0 to 10, zero being no pain at all and ten being the worst, rate your complaint by *circling the number*.

Problem. _____ 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ How did the problem(s) begin? _____

Is it: □ Getting better □ Getting worse □ Staying the same Has the problem(s) occurred before? □ Y □ N

How often do you feel the problem? □ Daily □ Weekly □ Monthly Other: _____

How long does it last? □ It is constant □ I experience it on and off during the day OR □ It comes and goes throughout the week

What makes it feel better? _____ What makes it feel worse? _____

Is there anything the doctor needs to know about this condition?_____

Do you suffer from any condition other than the one(s) you are now consulting us for? Even if you think it may not be related to chiropractic care, please list any conditions or health concerns:_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have currently or have experienced in the last 12 months:

General
- □ Fatigue
- □ Allergies
- □ Asthma
- □ Head Feels too Heavy
- □ Dizziness
- □ Loss of Balance
- □ Ringing in the Ears
- □ Poor Quality of Sleep
- □ Trouble Staying Asleep
- □ Weak Immune System
- □ Eczema/Psoriasis
- □ Headaches
- □ Migraines
- □ Cancer: _____

Cardio-Vascular
- □ Chest Pain
- □ Pins& Needles in Arms/Legs
- □ Shortness of Breath
- □ Blood Pressure Problems:
  □ □High □ □Low
- □ Irregular Heartbeat
- □ Heart Problems
- □ Lung Problems/Congestion
- □ Varicose Veins
- □ Ankle Swelling
- □ Stroke
- □ Angina

Nervous System
- □Nervousness
- □Numbness
- □Paralysis
- □Dizziness
- □Forgetfulness
- □Fainting
- □Convulsions
- □Twitching of the Face
- □Stress
- □Anxiety
- □Often feel overwhelmed
- □Trouble coping with daily living
- □Confusion

Male / Female
- □Menstrual Irregularity
- □Menstrual Cramping
- □Vaginal Pain/Infection
- □Breast Pain/Lump
- □Prostate/Sexual Dysfunction
- □Prostate Condition
- □Infertility
- □Hormonal Imbalance
- □PMS

Urinary
- □Bladder Troubles
- □Painful/Excessive Urination
- □Discolored Urine

Gastro-Intestinal
- □Excessive Thirst
- □Frequent Nausea
- □Vomiting
- □Diarrhea
- □Constipation
- □Hemorrhoids
- □Liver Problems
- □Gall Bladder Problems
- □Weight Trouble
- □Abdominal Cramps
- □Nervous Stomach
- □Stomach Troubles
- □Ulcers
- □Gas/Bloating after meals
- □Heartburn
- □Colitis
- □Crones
- □Irritable Bowl Syndrome
- □Intestinal Tract Disorder
- □Indigestion

Eyes/Ears/Nose/Throat
- □Dental Problems
- □Vision Problems
- □Sore Throat
- □Ear Aches/Infections
- □Hearing Difficulty
- □Stuffed Nose

Musculo-Skeletal
- □Low Back Pain
- □Pain btw shoulders
- □Heartburn
- □Neck Pain
- □Arm Pain
- □Joint Pain/Stiffness
- □Walking Problems
- □Clicking Jaw
- □General Stiffness
- □Inner Tension
- □Arthritis
- □Tendonitis/Bursitis
- □Spinal Disc Problems

Mental/Emotional
- □Addiction
- □Compulsions
- □ADHD
- □Depression
- □Irritability
- □Over eating
- □Under eating
- □Excessive exercise
- □Panic attacks
- □Use of alcohol
  _____oz/per day
- □Smoker
  _____ /per day

Familial History Please state family history of any disease or illness: _____

_____

Past Accident/ Trauma/ Injury History

How many car accidents have you been in? _____ Dates: _____

Any work, sports or other injuries? Please describe: _____

_____

Have you had X-rays taken in the last six months? □□Yes □□No If yes, where?:_____

Past Surgical History Please list any prior surgeries you have had and date: _____

_____

Lifestyle

Do you wear orthotics? □□Yes □ □No If yes, when did you start wearing this pair? _____

Do you wear a heel lift? □□Yes □□No If yes, when did you start wearing it/them? _____

Medications Please list the medications (prescription, over the counter and supplements) you are currently taking:_____

Women's Health Are you pregnant? □ Y □ N Are you nursing? □Y □ N Are you taking birth control medication? □Y □N