Dr. Pam Manning D.C.

253 Church Street, Markham, L3P 2M6
Tel. 905-294-2904

PERSONAL HISTORY

Date: _____

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Birth Date: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of Work: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

# of children _____

Referred To This Office By: _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Major Complaint: _____

Other Doctor's Seen For This Condition: _____

When Did This Condition Begin: _____

Are There Others In Your Family With This Same Condition: _____

If Disabled From Work Please Give Dates: _____

☐ Job Related ☐ Auto Related Date of Accident/Injury _____

Medication You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure

☐ Insulin ☐ Aspirin/Similar ☐ Other _____

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PAST HEALTH HISTORY

Please Check or Describe

Major Surgery/Operations: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart

☐ Back ☐ Neck ☐ Leg ☐ Other _____

Major Traumas (Car Accident/Falls/Sports Injuries:_____

_____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: Doctor's Name and Approximate Date of Last Visit: _____

_____

Have You Been Treated For Any Health Conditions In The Last Year? ☐ Yes ☐ No

If Yes, Please Explain: _____

Does Anyone Else In Your Family Have The Same Or Similar Condition? _____

Below is a list of diseases 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 DISEASES YOU HAVE HAD:

☐ Pneumonia	☐ Mumps	☐ Influenza	**INTAKE**
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Coffee
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Tea
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Alcohol
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ Cigarettes
☐ Anemia	☐ Heart Disease	☐ Lumbago	☐ White Sugar

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CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discoloured Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

FEMALES ONLY:

When was your last period? _____

Are you Pregnant?

☐ Yes ☐ No ☐ Not Sure