FAMILY FIRST chiropractic

Name _____
Address _____
City _____ Prov ____ PC _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)

Occupation _____
Marital Status S M D W
Spouse's Name _____
No. of children _____
Manitoba Health registration #_____
Referred By_____

Chiropractic History

Have you previously seen a chiropractor? ☐ Yes ☐ No Reason _____ Did they take x-rays? ☐Yes ☐ No
If yes, when was your last visit and how long did you receive care_____

Current Health Condition ☐ *I'm here for wellness and have no complaints (Please skip to the next section)*

Reason for today's visit _____
Pain or problem started on_____ Why do *you* think the problem/pain started? _____
Pain is: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent Pain is interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other _____
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is it worse during certain times of the day? _____ Is this condition getting progressively worse? ☐ Yes ☐ No
Other Doctors seen: _____ Any home remedies? _____

Other symptoms:

☐ Headaches
☐ Neck Pain / stiff
☐ Sleeping Problems
☐ Back Pain
☐ Nervousness
☐ Tension
☐ Irritability
☐ Chest Pains
☐ Dizziness
☐ Face Flushed
☐ Pins & Needles in Legs
☐ Pins & Needles in Arms
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Shortness of Breath
☐ Fatigue
☐ Depression
☐ Light Bothers Eyes
☐ Double Vision
☐ Loss of Memory
☐ Ears Ring / buzzing
☐ Fever
☐ Fainting
☐ Cold Sweats
☐ Loss of Smell
☐ Loss of Taste
☐ Difficulty Swallowing
☐ Diarrhea
☐ Feet Cold
☐ Hands Cold
☐ Stomach Upset
☐ Nausea
☐ Constipation
☐ Loss of Balance
☐ Ear Infections
☐ Asthma
☐ Allergies
☐ Frequent colds/flu
☐ Menstrual problems
☐ IBS / Crohn's disease
☐ Anxiety
☐ Multiple Sclerosis

Other conditions, diseases or concerns:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates. _____
Any work, sports or other injuries: _____
Any medications you are currently taking: _____
Have you had surgery? ☐ Yes ☐ No What type? _____ When?_____
Any significant family medical conditions/history: _____
Give a brief description of the physical nature of your work:_____
Rate your occupational stress (1-10, 10 being the most stressful) _____
What types of physical, emotional and chemical stressors have you experienced _____
_____
Do you smoke? ☐ Yes ☐ No How many per day? _____ Do you drink alcohol? ☐ Yes ☐ No How many per week? ____

As a result of my chiropractic care, I would like to: *(Please check all that apply)*

☐ Feel better quickly
☐ Improved function and performance
☐ Have a healthier spine and better postural alignment
☐ Have a better quality of life

Signature _____ Date _____