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 _____

Date of Accident _____ MPI Personal Claim Number _____
Please describe how the accident happened_____

_____

Were you the ☐ driver or ☐ passenger. Were you surprised by the impact? ☐ Yes ☐ No Did you brace yourself? ☐ Yes ☐ No
Did you collide with another car or object? ☐ Yes ☐ No Did you roll the car? ☐ Yes ☐ No
Where did the impact take place? ☐ Drivers side ☐ Rear end ☐ Front ☐ Passenger
Were you leaning forward at the time of impact? ☐ Yes ☐ No Was your head or body turned? ☐ Yes ☐ No
What was the speed of your vehicle when the accident occurred? _____ Speed of the other vehicle _____
Were you rendered unconscious? ☐ Yes ☐ No Did you feel pain immediately after the accident? ☐ Yes ☐ No
What are your major complaints/symptoms stemming from the accident?

_____

_____

Have you been in an accident before, If so when?_____

***In the 5 years prior to the collision, did you:***

Take time off work more than 4 weeks because of a previous injury or health problem? ☐ Yes ☐ No
Use prescription or OTC medication on a regular basis? ☐ Yes ☐ No Type_____
Experience any significant health problems requiring ongoing care? ☐ Yes ☐ No describe_____
Receive any chiropractic or physiotherapy sessions? ☐ Yes ☐ No date of last treatment: _____
Did they take x-rays? ☐Yes ☐ No
Experience any problems with anxiety, depression or substance abuse? ☐ Yes ☐ No _____

**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:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***Work status:***

Are you currently working? ☐ Yes ☐ No If no, indicate target return date: _____
Will a return to work worsen your condition? ☐ Yes ☐ No ☐ ??
Does your condition affect your ability to travel to and from the workplace? ☐ Yes ☐ No
Does your condition result in an inability to perform required tasks? ☐ Yes ☐ No
Does your condition pose a safety/health risk to yourself or your co-workers? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
How many per day? _____

***Accidents/Trauma/Injury History***

Any work, sports or other injuries: _____
Have you had surgery? ☐ Yes ☐ No What type? _____ When?_____
Any significant family medical conditions/history: _____

Signature _____ Date _____