PATIENT INTRODUCTION FORM AND CLINICAL RECORD

Today's Date_____

Name_____
(Last) (First) (Middle)
Spouse's name: (parents names if patient is a child)_____

Home Address:_____Postal Code:_____

Home Phone#:_____Fax#:_____E-Mail:_____

Sex_____Date of Birth _____Age_____Number of Children_____
(month) (day) (year)

Marital Status SINGLE MARRIED COMMON LAW WIDOWED DIVORCED(Circle One)

Occupation or Profession_____Business Phone #_____

Employed By_____

Have you had chiropractic before? Yes____No___By whom?_____

How long ago?_____Were x-rays taken? Yes____No___When?_____

Manitoba Health Number_____
(6 digit number) (9 digit number)
Are you claiming under Worker's Compensation Act? Yes_No___Claim Number:_____

Are you claiming under Manitoba Public Insurance? Yes__No___Claim Number:_____

What brings you to our office?_____

What daily work/recreation activities are being affected?_____

_____

How long has it been since you said: "I really feel great?"_____

I was referred by?_____I want Symptom care (____) Wellness Care (____)

Habits/usage:	Heavy	Moderate	Light	None
Alcohol	( )	( )	( )	( )
Coffee	( )	( )	( )	( )
Tobacco	( )	( )	( )	( )
Drugs	( )	( )	( )	( )
Exercise	( )	( )	( )	( )
	Excellent	Satisfactory	Poor	None
Sleep	( )	( )	( )	( )
Appetite	( )	( )	( )	( )

(over)

MARK AN "X" NEXT TO ANY SYMPTOMS YOU EXPERIENCE. THEY MAY CORRESPOND TO THE PROBLEM AREAS IN YOUR SPINE AND NERVOUS SYSTEM.

( ) Headaches
( ) Shooting head pains
( ) Sinus trouble
( ) Loss of smell
( ) Hay fever
( ) Asthma
( ) Loss of taste
( ) Tightness of throat
( ) Inflammation of throat
( ) Face flushed
( ) Twitching of face
( ) Loss of memory
( ) Fatigue
( ) Depression
( ) Head feels too heavy
( ) Dizziness
( ) Neck pain
( ) Fainting
( ) Loss of balance
( ) Ringing in ears
( ) Wearing glasses
( ) Lights bother eyes
( ) Muscle spasms in neck
( ) Grating in neck
( ) Tightness of shoulder muscles
( ) Pins and needles in arms and legs
( ) Cold hands
( ) Chest pains
( ) Shortness of breath
( ) Tuberculosis
( ) Heart pain
( ) Heart palpitation
( ) Mid-back pain
( ) Heart attacks
( ) High blood pressure
( ) Low blood pressure
( ) Anemia - low iron
( ) Rheumatic Fever
( ) Stomach trouble
( ) Abdominal bloating
( ) Ulcers
( ) Nervousness
( ) Tension
( ) Irritability
( ) Cold sweats
( ) Liver trouble
( ) Gall bladder trouble
( ) Indigestion
( ) Intestinal gas
( ) Low back pain
( ) Constipation
( ) Kidney trouble
( ) Arthritis
( ) Cancer
( ) Diabetes
( ) Swollen ankles
( ) Cold feet
( ) Sleeping problems
( ) Painful joints
( ) Swollen joints
( ) Slipped disc
( ) Pinched nerves in back
( ) Pins and needles in legs
( ) Pains in legs and feet

FOR WOMEN ONLY

( ) Menstrual cramps/pain
( ) Menstrual irregularity
( ) Excessive flow
( ) Breast lumps or tenderness

Date LMP_____

Do you have reason to believe you may be pregnant? Yes__No___Due Date:_____

Have you ever had any falls, accidents or injuries? Yes_____No_____

If yes, please explain (give month & year)_____

_____

Have you ever had any surgery? Yes_____No___Details_____

_____

Are you presently taking medication? Yes__No___What drugs and why?_____

_____

Are you taking food supplements (vitamins, minerals, or herbs)? Yes____No___Details_____

_____