Today's Date: _____ Reason for visit (check off): ☐ Chiropractic ☐ Athletic Therapy

ARORA FAMILY CHIROPRACTIC

PERSONAL INFORMATION

Name: _____ (on MB Health Card) Name I prefer to go by: _____

Male ___ Female ___ DOB: M ___/D____/Y___ Age: _____ Occupation: _____

Email address: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ # of Children: _____

MB Health Number (6 digits): _____ PHIN (9 digits): _____

(Note all residents of Mb are covered with Manitoba Health for a portion of their first 7 chiropractic adjustments)

*Who can we thank for referring you to our office or how did you find us? _____

Are you claiming under Manitoba Public Insurance? Y N Claim # _____ Date of MVA: _____

Are you claiming under Worker's Compensation? Y N Claim # _____ Date of injury: _____

……

REASON FOR TODAY'S VISIT

Please mark the statement that most closely describes your current goals for your health/well-being:
○ I want optimum health and well-being on every level available to me
○ I am mainly concerned about relief of a symptom and preventing its return
○ I am mainly concerned about relief of a particular symptom

What is the primary reason(s) for your visit today?
_____

When and how did this concern begin? _____

What in your **day to day life** is this affecting you the most?
_____

Have you been treated for this condition before and by whom?
_____

Have you received Chiropractic Care or Athletic Therapy before? Y N How long ago? _____

How much does the above health concern affect the following aspects of your life? Please circle.

0-Does **NOT** affect me **1**-Affects me **SLIGHTLY** **2**-Affects me **MODERATELY** **3**-Affects me **SIGNIFICANTLY**

WORK	0 1 2 3	**REST/SLEEP**	0 1 2 3	**EXERCISE**	0 1 2 3
ENERGY	0 1 2 3	**PERSONAL LIFE**	0 1 2 3	**SOCIAL LIFE**	0 1 2 3

Below is a list of conditions which may affect your overall course of care. Please answer carefully.

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

General
- ☐ Fatigue
- ☐ Headaches
- ☐ Migraines
- ☐ Head feels heavy
- ☐ Dizziness

Cancer: _____
- ☐ Diabetic
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Weak Immune System

Nervous System
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Confusion
- ☐ Forgetfulness
- ☐ Loss of Balance
- ☐ Convulsions
- ☐ Twitching of the Face
- ☐ Stress
- ☐ Anxiety
- ☐ Often feel overwhelmed

Gastro-Intestinal
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Indigestion
- □ Irritable Bowel
- □ Weight Trouble
- □ Abdominal Cramps
- □ Nervous Stomach
- □ Stomach Trouble
- □ Ulcers

Musculo-Skeletal
- □ Low Back Pain
- □ Mid Back Pain
- □ Neck Pain
- □ Arm/Shoulder Pain
- □ Knee/Elbow Pain
- □ Jaw Pain
- □ General Stiffness
- □ Arthritis
- □ Tendonitis/Bursitis
- □ Scoliosis

Mental/Emotional
- □ Addictions
- □ Compulsive Behaviour
- □ ADHD
- □ Depression
- □ Irritability
- □ Overeating
- □ Undereating
- □ Cravings eg. Sugar, breads
- □ Panic attacks
- □ Use of alcohol

  ____oz. per day
- □ Smoker

  ____ per day
- □ Cannibas

  ____ in the past 24 hours?

Cardio-Vascular
- ☐ Chest Pain
- ☐ Pins & Needles in Arms/Legs
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems

  ○ High ○ Low
- ☐ Irregular Heartbeat
- ☐ Cholesterol
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Angina

Male/Female
- □ Menstrual Irregularity
- □ PMS
- □ Breast Pain/Lump
- □ Prostate/Sexual Dysfunction
- □ Prostate Condition
- □ Infertility
- □ Hormonal Imbalance
- □ Are you Pregnant?

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

Eyes/Ears/Nose/Throat
- □ Ringing/Buzzing in Ears
- □ Vision Problems
- □ Sore Throat
- □ Ear Aches/Infections
- □ Hearing Difficulty

Family History of: (Please check all that may apply)

□ Heart Disease M / F □ Cancer M / F □ Arthritis M / F □ Diabetes M / F Other:_____

LIFESTYLE

How would you rate your stress level? 1(low) to 10(high): Current _____ Your life in general_____

How much do you sleep every night? _____ Broken?_____

Do you exercise? What kind and how often? _____

How is your diet? Comments? _____

Medications? For how long?_____

How would you rate your health from a scale of 1 (low) to 10 (high)? _____

PAST ACCIDENT/TRAUMA/INJURY HISTORY

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

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

_____

Have you ever had X-rays/MRI/CT scans taken of your spine?(circle) □ YES □ NO If yes, where and when?

_____

Please list any prior surgeries you have had and date:

_____