Today's Date: _____

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? _____

Have you received chiropractic care before? Y N How long ago? _____

Were you pleased with your care? Y N _____

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: _____

If you are claiming under MPI or WCB, please let our chiropractic assistants know right away.

……

The human body is designed to express health and function normally. However, events may occur in life which can interfere with this natural ability. This interference is most commonly caused by vertebral subluxations, resulting from physical, chemical, or emotional stress. Chiropractic aims to locate and correct the vertebral subluxation and nerve interferences to optimize health

……

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) and/or health concern(s) for your visit today?

_____

When and how did this concern begin? _____

How is this concern mainly **AFFECTING** your **QUALITY OF LIFE**?

_____

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

_____

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
DIGESTION	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 chiropractic 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

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)? _____ Would you like us to help improve this?_____

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:
_____