PATIENT HISTORY

(PLEASE PRINT) Male ☐ Female ☐ Date: ______________

Name: ______________________________ **MB Health Card #** __________ / __________
6 digit **9 digit**

Address: ____
(Box/Street) (City) (Postal Code)

Email: ______________________________
☐Monthly Newsletter ☐Birthday Greetings ☐Appointment Reminders

Phone (H): __________ (W): ______________ Cell: __________

Birthday (D/M/Y): ______________ Age: _____ Marital Status: ________ # of Children: _____

Spouse/Parent's Name: ________________ Who referred you to this office? ______________

Occupation: ______________ Employer: ______________ Work Address: ____________

Have you had chiropractic care before? Yes ☐ No ☐ By Whom? ______________________

For what condition? __________________ Date of Last Adjustment: ______________

HOW CAN WE HELP YOU TODAY? ____

____

Is this the result of a car accident or a work injury? (Circle) Autopac or Workers Comp

List other doctors consulted for these conditions:

1. ______________________________ Address ____________________

2. ______________________________ Address ____________________

Are you pregnant? Yes ☐ No ☐ Due Date: __________

Do you have any other health problems other than the ones listed? (explain) ____________________

____

Please name any medications and what you take them for: ______________________________

How long has it been since you really felt well? ______________________________

Is your condition interfering with your work or home life? (comments) ____________________

★Please check the type of care desired so that I may be guided by your wishes, when possible:

Temporary Relief ☐ Control of Immediate Problem ☐ Total Health Care and Correction ☐

Do you have any type of Private or Group Health Insurance? Yes ☐ No ☐

Thank-you for taking the time to fill out this form!