PATIENT HISTORY

(PLEASE PRINT)

Date: _____

Name: _____ MB Health Card # _____/_____

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: _____

Previous Chiropractic Care: Yes ☐ No ☐ By Whom? _____ Date Of Last Adjustment: _____

For What Condition? _____

HOW CAN WE HELP YOU TODAY? _____

_____

Location: _____ Quality: DULL SHARP THROB ACHE
(where is the pain/problem?) (please circle)

Severity: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain Duration: _____
(How long have you had the problem?)

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

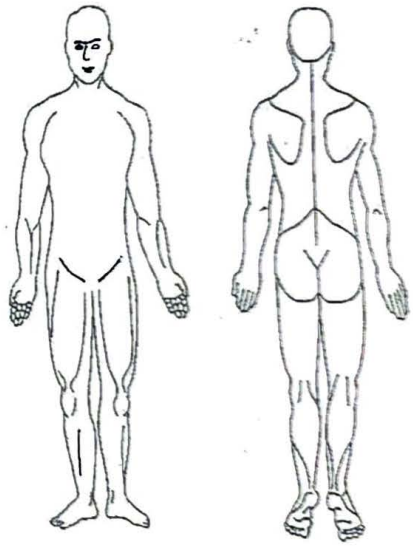
List other doctor's consulted for these conditions:
1. _____

Address: _____

2. _____

Address: _____

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



↑ Indicate Location ↑ Of Pain

When did you last feel really well? _____

Is you condition interferring with your home life or work life? (Comments) _____

_____

Do you have any other health problems? (explain) _____

_____

Please name any medications & what your taking them for: _____

***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 ☐

Please Indicate: _____

PLEASE COMPLETE OTHER SIDE

Past Medical History:
(Please check if you have had any one of the following)

- □ Measles
- □ Mumps
- □ Chicken Pox
- □ Whooping Cough
- □ Scarlet Fever
- □ Diphtheria
- □ Smallpox
- □ Pneumonia
- □ Rheumatic Fever
- □ Heart Disease
- □ Arthritis
- □ Venereal Disease
- □ Anemia
- □ Bladder Infections
- □ Epilepsy
- □ Migraine headaches
- □ Tuberculosis
- □ Diabetes
- □ Cancer
- □ Polio
- □ Glaucoma
- □ Hernia
- □ Blood Transfusion
- □ Plasma Transfusion
- □ Back Trouble
- □ High Blood Pressure
- □ Low Blood pressure
- □ Hemorrhoids
- □ Chest X-Ray - Date
- □Asthma
- □ Hives or Eczema
- □ AIDS or HIV
- □ Infectious Mono
- □ Bronchitis
- □ Mitral Valve Prolapse
- □ Stroke
- □ Hepatitis
- □ Ulcer
- □ Kidney Disease
- □ Thyroid Disease
- □ Bleeding Tendency
- □ Other Disease's - Please Specify

_____
_____
_____
_____
_____

Review of Symptoms:
(Please check any personal history below)

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfullness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

GASTROINTESTINAL
- □ Appetite Poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Thirst
- □ Gas
- □ Hemorroids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting
- □ Vmiting Blood

MUSCLE/JOINT/BONE
Pain, weakness, or numbness in:

- □ Arms
- □ Back
- □ Neck
- □ Feet
- □ Hands
- □ Legs
- □ Shoulders
- □ Hips

CARDIO/RESPIRATORY
- □ Chest Pain
- □ Shortness of Breath
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Varicose Veins
- □ Swelling of Ankles
- □ Irregular Heart Beat
- □ Poor Circulation
- □ Rapid Heart Beat

GENITO-URINARY
- □ Blood in Urine
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

EYE, EAR, NOSE & THROAT
- □ Blurred Vision
- □ Crossed Eyes
- □ Difficulty Swallowing
- □ Double Vision
- □ Earache
- □ Ear Discharge
- □ Hay Fever
- □ Hoarseness
- □ Loss of Hearing
- □ Nosebleeds
- □ Persisitant Cough
- □ Ringing in ears
- □ Sinus Problems
- □ Vision - Flashes
- □ Bleeding Gums
- □ Vision - Halos

SKIN
- □ Hives
- □ Itching
- □ Bruise Easily
- □ Sores that Won't Heal
- □ Change in Moles
- □ Scars
- □ Rash

NUTRITION
- □ Swallowing Problems
- □ Appetite Problems
- □ Taking Nuttitional Supplements
- □ Significant weightloss/ weight gain

MEN ONLY
- □ Breast Lump
- □ Erection Difficulties
- □ Lump in Testicles
- □ Penis Discharge
- □ Sore on Penis
- □ Other

WOMEN ONLY
- □ Abnormal Pap Smear
- □ Bleeding Between Periods
- □ Breast Lump
- □ Extreme Menstral Pain
- □ Hot Flashes
- □ Nipple Discharge
- □ Vaginal Discharge
- □ Painful Intercourse

OTHER
- □ Date of Last Menstruation:

_____
Date of Last Pap Smear:
_____
- □ Are You Pregnant □No □Yes
- □ Number of Children: _____

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Panic attacks
- □ Difficulty dealing with Stress
- □ Suicidal Thoughts

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctors office of any changes in my medical status.

_____ _____
Signature of Patient, Parent or Guardian **Date**

_____ _____
Signature of Patient, Parent or Guardian **Date**

Signature above confirms all items have been reviewed, unchecked items are non-contributory.

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM!