



PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____ Date of Birth (dd/mm/yyyy): _____ (Age _____)
 Address: _____ Sex: M F MB Health Card 6 digit #: _____
 City: _____ Prov.: _____ Postal: _____ Are you or might you be pregnant? Yes No
 Phone: (H) _____ (W/C) _____ Occupation: _____
 Email: _____ Spouse's Name: _____
 Referred By: _____

<i>Number of Children and Ages:</i>		<i>Have they had previous Chiropractic Care?</i>	
Name _____	Age _____	Yes / No	Reason _____
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Why this form is important – You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove this interference to your natural health expression so that you and your family may have the opportunity for a **lifetime of health and happiness**.

Many health challenges people face later in life may have their origins in stresses from the developmental years, some even starting at birth.

Circle All That Apply	Patient	Child#1	Child#2	Child #3	Child #4	Comments/Details
1. Was Your Birth Traumatic? (Circle if you know...)						
Long delivery?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Difficult delivery?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Forceps / vacuum extractor?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Caesarian section?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Breach/cephalic?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Mother given drugs/epidural during birth?	Y / N	Y / N	Y / N	Y / N	Y / N	_____
Induced labour?	Y / N	Y / N	Y / N	Y / N	Y / N	_____

2. Growth and Development (Childhood Years: Ages 0-17 years) – If Yes, please write details

Did you ever...		
Have chiropractic care?	Y / N	_____
Fall while learning to walk?	Y / N	_____
Have any other falls or accidents?	Y / N	_____
Have surgery? (dates, type)	Y / N	_____
Have recurrent childhood illness/sickness?	Y / N	_____
Take drugs (eg. antibiotics, vaccines)?	Y / N	_____
Experience other traumas/ stress?	Y / N	_____

3. Current Health Habits (Adult Years: Ages 18 to present) – If Yes, please write details

Did/do you...		
Utilize chiropractic care (prior to today)?	Y / N	_____
Eat healthy foods regularly?	Y / N	_____
Drink 8-10 cups of water daily? (#cups/day)	Y / N	_____
Exercise regularly? (type, duration)	Y / N	_____
Smoke? (how much/week)	Y / N	_____
Drink? (# drinks/week)	Y / N	_____
Have you been in car accidents? (dates)	Y / N	_____
Utilize drugs? (list prescription/non-prescrip.)	Y / N	_____
Have surgery? (dates, type)	Y / N	_____
Have high mental stress?	Y / N	_____
Have high physical stress?	Y / N	_____
Have hobby or sports injuries? (dates, injury)	Y / N	_____

Have sleeping problems? Y / N _____
Sleeping position: side; stomach; back ? _____
Number and type of pillows used? _____

Nutritional Supplements? (list all) Y / N _____

What are your current health goals? (eg: Get out of pain, lose weight, eat healthier, quit smoking, walk 5 miles, etc.)

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Present complaint (Reason for your visit today) _____

Pain or problem started how and when? _____

Pain or problem occurred before? _____

What activities make your condition / pain worse? _____

What activities make your condition / pain better? _____

How long has it been since your really felt good? _____

If you have pain, is it... sharp dull radiating constant intermittent
 mild moderate mod-severe severe

Since it began, is it... about the same variable getting better getting worse

What time of day is it worst? waking at work evening at night variable constant

Does it interfere with... work sleep walking sitting exercise other _____

OTHER SYMPTOMS (even if they do not seem related to your current condition):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> arthritis/joint problems | <input type="checkbox"/> sinus problems / allergies | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> neck stiffness / pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart problems / stroke |
| <input type="checkbox"/> shoulder stiffness / pain | <input type="checkbox"/> dizziness / vertigo | <input type="checkbox"/> constipation / diarrhea | <input type="checkbox"/> cancer |
| <input type="checkbox"/> pins & needles in arms | <input type="checkbox"/> tension / stress | <input type="checkbox"/> problems urinating | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> nervousness / anxiety | <input type="checkbox"/> cold sweats | <input type="checkbox"/> recurring infection |
| <input type="checkbox"/> back stiffness / pain | <input type="checkbox"/> irritability / mood swings | <input type="checkbox"/> hot flashes | <input type="checkbox"/> loss of smell / taste |
| <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> depression | <input type="checkbox"/> menopause | <input type="checkbox"/> vision changes |
| <input type="checkbox"/> numbness in feet / toes | <input type="checkbox"/> stomach upset | <input type="checkbox"/> PMS / menstrual cramps | <input type="checkbox"/> buzzing / ringing in ears |
| <input type="checkbox"/> foot problems | <input type="checkbox"/> heartburn / reflux | <input type="checkbox"/> infertility / impotence | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> jaw / TMJ problems | <input type="checkbox"/> ulcers | <input type="checkbox"/> cold hands / feet | <input type="checkbox"/> chest pains |
| <input type="checkbox"/> other _____ | | | |

As a result of my Chiropractic Care, I would like to: (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> <i>Feel better quickly</i> | <input type="checkbox"/> <i>Have a healthier body by keeping my nerve system healthy</i> |
| <input type="checkbox"/> <i>Have a healthier spine</i> | <input type="checkbox"/> <i>Live a healthier, more active lifestyle</i> |

The above stated is true. I clearly understand and agree that all services rendered to me that are not covered by Manitoba Health, WCB, or Autopac are charged directly to my account and that I am responsible for payment when services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I consent to being treated in an open area and understand that a private room is available should I request one.

Signature

Date

To help share chiropractic miracles and celebrate special occasions, I consent to my photograph and name being used in the office for recognition.

Signature

Date