Mommy&Me
Family Chiropractic

**Today's Date:**_____

Patients Name :_____ Referred by:_____
Home Address: _____
Postal code:_____ City:_____ Province:_____
Phone:(H)_____(C)_____(W)_____
Occupation: _____E-mail Address: _____
Marital Status: S M D W Spouses Name:_____ (Ph.)_____
No. of children and ages:_____
Manitoba Health Registration No._____ PHIN #: _____
Date of Birth : _____

## Chiropractic History

Have you previously seen a chiropractor? ☐Y ☐N If yes, with whom? _____
If Yes, when was your last visit ?_____
Have you ever had x-rays taken? ☐Y ☐N If yes, when and where? _____

## Current Health Condition ☐ *I'm here for wellness and have no complaints (Please skip this section)*

Reason for today's visit? _____
When did it start?_____ Why do you think it started?_____
How has your condition/pain been progressing: ☐ Getting worse ☐ Better ☐ Staying the same
Does anything make your condition/pain better? _____
Does anything make your condition/pain worse? _____
Is your condition/pain worse during certain times of the day? _____
Rate your pain/ discomfort on a scale of 0-10 with 0 being no pain/discomfort and 10 being the worst pain/ discomfort imaginable: At It's best: _____At It's worst: _____ Currently:_____
Are you experiencing any other signs/symptoms that go along with your main concern? ☐Y ☐N If yes, please explain:_____
Have you seen anyone else for this complaint? ☐Y ☐N If yes, with whom? _____
What were the results? _____
What was the treatment? _____

**Please check all symptoms you are currently experiencing or have in the past:**

□ Headaches
□ Neck Pain
□ Sleeping Problems
□ Back Pain
□ Nervousness
□ Ears Ring/Buzzing
□ Fever
□ Fainting
□ Cold Sweats
□ Loss of Smell
□ Tension
□ Irritability
□ Chest Pains
□ Dizziness
□ Allergies
□ Loss of Taste
□ Difficulty Swallowing
□ Asthma
□ Cold Feet
□ Double Vision
□ Loss of Memory
**Pins & Needles in**:
□ **Legs** □ **Arms**
□ **Fingers**□ **Toes**
□ Cold Hands
□ Frequent Colds
□ Pubic Pain
□ IBS
□Weakness
□Numbness
□ Shortness of Breath
□ Fatigue
□ Depression
Other Conditions or concerns:
_____
_____
_____
□ Light Bothers Eyes
□ Loss of Balance
□ Multiple Sclerosis
□ Leg / Calf cramps

**Accidents/Traumas/Injuries**

No. of car accidents: _____ Approximate dates: _____

Any Injuries/ broken bones? ☐Y ☐N If yes, please explain _____

Any Hospitalizations? ☐Y ☐N If yes, please explain _____

Any Surgeries? ☐Y ☐N If yes, please explain: _____

Please list family medical history:_____

**Current Health**

How often would you say you engaged in physical activity: ☐0x/wk ☐1-3x/wk ☐4-7x/wk

How would you describe your diet: ☐ poor ☐fair ☐good ☐excellent

Do you smoke? ☐Y ☐N How many cigarettes per day? _____

Do you drink alcohol? ☐Y ☐N How many drinks per week? _____

Are you currently taking any prescribed or OTC medications? ☐Y ☐N If yes, please list: _____

_____

What are your health goals? _____

_____

**As a result of my chiropractic care, I would like to: (Please check all that apply)**

□ Feel better quickly □ Have a healthier spine and nervous system □ Better postural alignment

□ Improved function and performance □ Have a better quality of life

**Signature:**_____ **Date:**_____