CONNECT CHIROPRACTIC
Connecting the dots to optimal health
73 Goulet St.|Winnipeg|MB|R2H 0R5 P. 204-237-6726

NEW PATIENT HEALTH HISTORY

In order to give you the best care possible, please complete this health history as thoroughly as possible. All information is strictly confidential.

Today's Date: _____

Patient Data

Full Name: _____ Name of Preference: _____Sex: ☐ M ☐ F
Address: _____ City: _____ Prov:____ Postal Code: _____
Telephone: (Home)_____ (Cell)_____
Birth date: _____ (M/D/Yr) Age: _____
Occupation: _____ Employer: _____

E-mail: _____ ☐ Check box if you consent to receiving informational emails from us on holiday hours, promotions, etc.
Marital Status: _____ Name of Spouse (if applicable): _____
Ages of Children (if applicable): _____

Have you been to a Chiropractor before? ☐ Yes ☐ No
If yes: Which office:_____ When: _____
How did you find out about our office? _____
If you were referred by someone, whom can we thank for referring you? _____

Addressing What Brought You Into This Office – Health Concerns

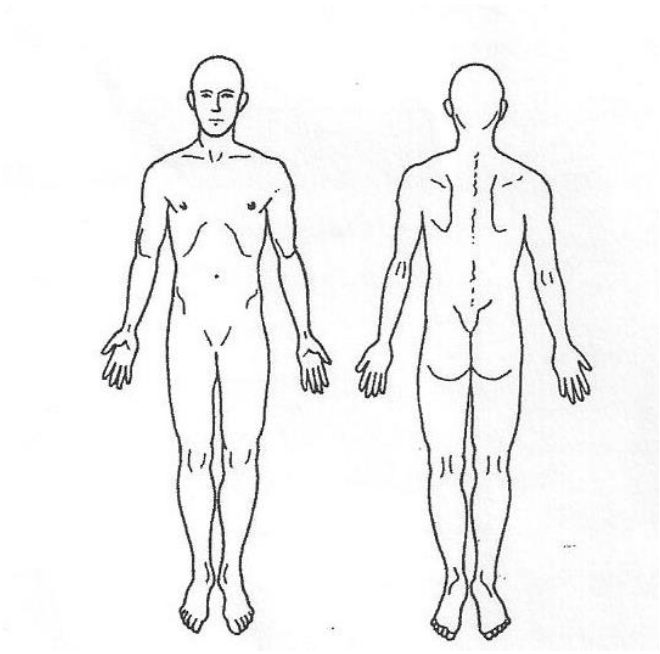
Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull or sharp (circle)? Does it radiate anywhere? If so, where?_____

Is this a Worker's Compensation Case? ☐ Yes ☐ No
If yes, date of injury? _____ Type of injury? _____Claim #_____
Name and phone number of *adjuster*? _____

Did your complaint(s) arise from a *Motor Vehicle Accident (MPI)*? ☐ Yes ☐ No
If yes, date of injury? _____ Collision type (i.e. rear-ended) _____Claim #_____
Name and phone number of *adjuster*? _____

Please circle your area of complaint(s) on diagram and indicate the type of pain/discomfort (A=*Achy, D=Dull, S=Sharp/Stabbing, B=Burning, N=Numbness, P=Pins and Needles, or Other*:_____) next to the area.



On a scale of 0 (no pain) to 10 (intense pain), please indicate current level of pain next to each area?

If complaint is due to an action or event, please explain:

_____

_____

How long have you been living this way? ____ Days, ____ Weeks, ____ Months, or ____Years

Did your complaint(s) come on: ☐ Suddenly ☐ Gradually

Is the complaint(s) getting: ☐ Better ☐ Same ☐ Worse

Is the condition worse in the: ☐ AM ☐ PM ☐ No change

Is the complaint: ☐ Constant ☐ Intermittent ☐ Worse with movement

This condition interferes with my: ☐ Sleep ☐ Work ☐ Family Life ☐ Exercise ☐ Other _____

What aggravates your condition/pain?

_____

What (if anything) relieves your condition/pain?

_____

If you have or are currently receiving other treatment, please describe type of treatment and results:

_____

_____

Name of General Practitioner (M.D.) _____ **Date last seen**: _____

Have you had any of the following in the last two years? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Bone Scan

☐ Bone Density test If yes, when and which area(s) of body? _____

Do you wear orthotics or heel lifts: ☐ Yes ☐ No

Other Symptoms and Conditions

Have you ever had, or do you presently have any of the following? Please note for how long and any associated medications.

☐ Headaches _____	☐ Neck pain/stiffness _____	☐ Back pain/stiffness _____	☐ Ringing in ear(s) _____
☐ Vision changes _____	☐ Loss of balance _____	☐ Dizziness or fainting _____	☐ High Blood Pressure _____
☐ Chest Pain _____	☐ Stroke _____	☐ High cholesterol _____	☐ Sleep problems _____
☐ Fatigue _____	☐ Asthma _____	☐ Allergies _____	☐ Sinus problems _____
☐ Digestive disorder _____	☐ Thyroid disorder _____	☐ Poor concentration _____	☐ Mood swings _____
☐ Depression/Anxiety _____	☐ Auto immune dis. _____	☐ MS _____	☐ Menopause _____
☐ Constipation _____	☐ Sexual Dysfunction _____	☐ Numb/tingling legs _____	☐ Numb/ting. hands _____
☐ Cold hands/feet _____	☐ Diabetes _____	☐ Osteoporosis _____	☐ Skin disorder _____
☐ Frequent colds _____	☐ Arthritis- Where? _____	☐ Seizures _____	☐ Kidney Disease _____
☐ Liver Disease _____	☐ History of Cancer _____	☐ Drug abuse _____	☐ Other _____

Please list any other medications: (Please include oral contraceptives and over the counter products)

_____

_____

List any surgeries: (Type and date)

_____

_____

Is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other
Mother's side	☐	☐	☐	☐	☐	_____
Father's side	☐	☐	☐	☐	☐	_____

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Improving ☐	Declining ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Improving ☐	Declining ☐

Stressors

Because the accumulation of stress affects our health and ability to heal, please indicate which stressors may have affected your health:

Physical Stress	Yes	No	Date and/or pertinent details
Any notable falls?	☐	☐	_____
Any significant injuries or illnesses?	☐	☐	_____
Any surgeries or prolonged medications?	☐	☐	_____
Past motor vehicle accident(s)?	☐	☐	_____
Slips or Falls?	☐	☐	_____
Hobby or sports injuries?	☐	☐	_____
Poor posture?	☐	☐	_____
Extended hours at a computer?	☐	☐	_____
Repetitive strain?	☐	☐	_____
Occupational stress?	☐	☐	_____

Sleeping posture

☐ Side ☐ Back ☐ Stomach

Approximate age of bed _____

Bio-Chemical Stress			
Smoke?	☐	☐	_____
Drink alcohol?	☐	☐	_____
☐ Daily ☐ Weekends ☐ Occasional			
Exercise regularly?	☐	☐	_____
☐ Daily ☐ Weekends ☐ Occasional			
Eat as healthy as you think you should?	☐	☐	_____
Healthy weight?	☐	☐	_____

Mental/Emotional Stress			
Mental stress?	☐	☐	_____

Where on a scale of 0-10? **At work: __/10 At home: __/10 At play__/10**

Consent for Chiropractic Examination & Release of Information

____ **(Please Initial)** I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

____ (Please initial) I hereby grant permission to the employees of Connect Chiropractic to communicate with other health care professionals, WCB, MPI, or third party insurance companies regarding my care and progress.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient name:_____

Signature: _____ Date: _____