Adult Initial Patient Form

Name (on your MB Health card): _____Preferred Name: _____

6 Digit MB Health #:_____9 Digit MB Health (PHIN) #:_____

Address: _____City: _____ Postal Code: _____

Age: ____ Birth date: (M)____/(D)____/(Y)_____ Status: M S W D Sex: M F N/B

Occupation: _____ Workplace: _____

Phone (C): _____ Phone (H): _____Phone (W): _____

Email address: _____

Name of Spouse: _____ # of Children: _____ their ages: _____

Reason for consulting our office: _____

Markham Chiropractic Centre may use this information to send you wellness tips and other offers.

WHY IS THIS FORM IMPORTANT?

On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (to age 17)

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your abilities.

Yes	No	Childhood (to age 17)	Patient Comment if Yes	Chiropractor Comments
__	__	Did you ever have any childhood illnesses?	_____	_____
__	__	Did you have any serious falls as a child?	_____	_____
__	__	Did you play youth sports?	_____	_____
__	__	Did you take/use any medications?	_____	_____
__	__	Did you have any surgeries?	_____	_____
__	__	Have you fallen/jumped from a height over three feet?	_____	_____
__	__	Were you involved in any car accidents as a child?	_____	_____
__	__	Was there any prolonged use of medicine?	_____	_____
__	__	Did you suffer other traumas(physical or emotional)?	_____	_____

__ __ Were there any difficulties during your birth? _____ _____

__ __ As a child, were you under regular chiropractic care? _____ _____

ADULT (18 to present)

Yes	No	Adult (18-present)	Patient Comment if Yes	Chiropractor Comments
__	__	Did/do you smoke?	_____	_____
__	__	Did/do you drink alcohol?	_____	_____
__	__	Exercise regularly?	_____	_____
__	__	Hobbies/sports injuries	_____	_____
__	__	Other traumas or problems	_____	_____

On a scale of 1 – 10 describe your stress level: (1=none, 10=extreme)

Occupational _____ Personal _____

On a scale of Poor, Good, Excellent (P, G, E), describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Please check any you have ever had in the past, even if they do not seem related to your current problem.

1) Balance Problems (loss of balance, dizziness, fainting) __

2) Digestive System (stomach upset, heartburn, constipation, diarrhea, ulcers) __

3) Musculoskeletal System (pins and needles in face, arms and legs, back pain, buzzing in ears, headaches, neck pain, neck stiffness) __

4) Mood Changes (mood swings, nervousness, depression) __

5) Hormonal Changes (menstrual irregularity, hot flashes, menstrual pain) __

6) General Health Issues (fatigue, sleeping problems) __

7) Loss of Senses (smell, taste, vision, light bothers eyes) __

8) Renal System (problem urinating, kidney, bladder) __

List any medications you are taking and for what reason: _____

_____

For reasons pertaining to Manitoba Health, we would like to know the following:

Have you had previous chiropractic care? _____ Where? _____ When? _____

Why? _____ Dr: _____ Were X-rays taken? _____

What is your major complaint presently? _____

_____

List all surgical operations and years: _____

Drugs you now take: __ Anti-inflammatory __ Pain Killers __ Muscle relaxers __ Blood Pressure

__ Tranquilizers __ Insulin __ Birth control pills __ Other:

Have you been in an automobile accident? __ NO __ Past year __ 2-5 years __ Over 5 years

Describe the accident: _____

Have you had any other personal injury or accident? __ None __ Past year __ 2-5 years __ Over 5 years

Describe the accident: _____

Is there a possibility that you may be pregnant? __YES __NO

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

How did you hear about our office? ___ Friend ___ Family ___ Sign ___ Internet ___ Other _____

Who can we thank for referring you to our office? _____

The statements made on these forms are accurate to the best of my recollection and I agree to allow Markham Chiropractic Centre to examine me, make diagnostic images of me, treat me, and do everything necessary, in accordance with the law, for my chiropractic care and management. I also understand and agree that I am solely responsible for payments on all services rendered that are not covered by Manitoba Medicare, Workers Compensation or Autopac.

_____ _____

Signature of Patient/Guardian/Spouse Date