ZAHARIA CHIROPRACTIC

Date: _____

Full Name:_____ Preferred Name:_____ Sex: ◯ Female ◯ Male

Address: _____ City, Prov., Postal Code:_____

Home Phone #:_____ Work #:_____ Cell #:_____

Birth Date:_____ (Age:_____) Email:_____

Name of Spouse/Partner:_____ Names/Ages of Children: _____

Occupation/Employer: _____

Emergency Contact:_____

How did you discover our office? _____

Have you been under Chiropractic care before? ◯ Yes ◯ No

How would you rate your experience? ◯Positive ◯Negative ◯Neutral Reason:_____

MANITOBA HEALTH NUMBERS
REG#:_____

PH ID (9 digits):_____

If you have seen a chiropractor this year, please provide date of last visit and # of visits you've already had <u>this year</u>?

_____

CURRENT AND PAST HEALTH HISTORY

*****If today's visit is due to an Auto Accident or Work Injury – Please ask for additional forms**

Please use this space to describe the reason for today's visit.

Major Concern: _____ When did it start? _____

Since the problem started, is it: ◯Getting Better ◯About the same ◯Getting Worse

What makes it better? _____

What makes it worse? _____

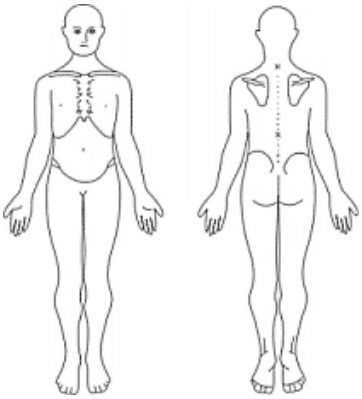
Any associated symptoms? _____

Other Doctors seen for this problem: ◯Yes ◯No If yes, what was the diagnosis and treatment? _____

_____

_____

<u>Location/Area of Concern</u>:



Quality of pain: ◯Dull ◯Sharp ◯Travels ◯Constant ◯Comes and goes

_____

Interferes with: ◯Work ◯Sleep ◯Walking ◯ Sitting ◯Leisure Activities

_____

Any other concerns/reason for today's visit?_____

_____

_____

Doctor's Notes:

_____

_____

_____

Please indicate if you currently or have recently experienced any of the following:

◯ Rashes	◯ Frequent coughs	◯ Varicose Veins	◯ Changes in Mood
◯ Headaches	◯ Chest pain	◯ Arthritis	◯ Changes in Memory
◯ Wear glasses	◯ Fever	◯ Gout	◯ Difficulty Lifting/Bending
◯ Changes in Vision	◯ High Blood Pressure	◯ Seizures	◯ Loss of Coordination
◯ Changes in Hearing	◯ Heart murmur	◯ Weakness	◯ Muscle Spasms
◯ Dizziness	◯ Changes in Weight	◯ Tremors	◯ Emotional stress
◯ Frequent colds/flu	◯ Nausea	◯ "Pins/Needles"	◯ Anxiety
◯ Allergies	◯ Heartburn/Acid Reflux	◯ Anemia	**Women's Health**
◯ Asthma	◯ Diarrhea/Constipation	◯ Thyroid Issues	◯ Menstrual Difficulties
◯ Sensitives (Food/drugs/pollen etc)	◯ Indigestion	◯ Hormonal Imbalances	◯ Menopause Difficulties
◯ Sore Throat	◯ Frequenting vomiting	◯ Sexual dysfunction	◯ Pregnancy
◯ Lumps/swollen glands	◯ Abdominal Pain	◯ Fertility Dysfunction	**Men's Health**
◯ Lumps/Pain in breasts	◯ Changes in Urination or Bowel	◯ Depression	◯ Erectile Difficulties
◯ Shortness of breath	◯ Leg Cramps	◯ Sleep Problems	◯ Prostate Dysfunction

Please indicate if you have a history of any of the following: (If yes, please provide as much detail as possible)

Injury with Auto Accident? ◯ Y ◯ N _____

Work Injury? ◯ Y ◯ N _____

Major Falls/Traumas? ◯ Y ◯ N _____

Surgeries? ◯ Y ◯ N _____

Do you exercise? ◯ Y ◯ N (How often? How long? Type?)_____

Have you ever been diagnosed with any physical disabilities or deformities? ◯ Y ◯ N If yes, please describe _____

_____

Have you recently taken or currently using the following: (If yes, please provide as much detail as possible)

Medications/Prescriptions? ◯ Y ◯ N _____

Vitamins/Supplements? ◯ Y ◯ N _____

Vaccinations? ◯ Y ◯ N _____

Recreational Drugs? ◯ Y ◯ N _____

Smoking/tobacco use? ◯ Y ◯ N _____

How often and how much do consume the following:

Alcohol _____ Pop (Reg or Diet)_____ Coffee/Caffeine _____

Water _____ Snack/Fast Food _____ Fruits/Vegetables _____

Do you have any food allergies? ◯ Y ◯ N (If any, please list) _____

Have you ever been diagnosed with any mental/psychological disorders? _____

Have you ever been diagnosed with a chronic illness (such as cancer, heart disease, diabetes, etc.)? _____

_____

List any family history of diseases/conditions: _____

_____

Please share any other health information you feel would be helpful:

_____

_____

The information provided on these forms is confidential. Signing this form gives consent to the doctor to examine you for evaluation.

X _____ Date: _____

Signature of Patient, or Guardian if under age