Whom may we thank for referring you to our office? _____

NIVERVILLE FAMILY CHIROPRACTIC

2 - 166 Main St., Niverville, MB R0A 1E0
204.388.6195

PATIENT HISTORY FORM

Today's Date: _____

Name_____ MHSC # _____ Reg# _____
(As it appears on MHSC card)
Date of Birth _____/_____/_____ Current Age_____ Height_____
(day / month / year)
Address _____ City _____ Province _____ Postal Code_____

Phone: Home _____ Work _____ Cell _____

Email Address _____ Occupation _____

Employer _____ Spouse's Name _____

Names and ages of children _____ Are you pregnant? Yes/No (Circle)

Will you be claiming: Autopac (MPI) Yes ☐ No ☐ Worker's Compensation Yes ☐ No ☐

If yes: Injury/Accident Date: _____ Personal Injury Claim # _____

CHIROPRACTIC HISTORY:

Have you been to a chiropractor before? Y ☐ N ☐ Date of last visit: _____
Name of last chiropractor: _____
What are your health goals in our office:
☐ Symptom Relief ☐ Wellness Care ☐ 100% Vitality & Health

HEALTH HISTORY:

Please rate your overall health status:
Poor 1 2 3 4 5 6 7 8 9 10 Excellent
Are you healthier today than you were five years ago? Y ☐ N ☐
If yes, what have you done to improve your health?_____
_____

WHAT IS YOUR MAJOR COMPLAINT FOR WHICH YOU ARE SEEKING CHIROPRACTIC CARE?

_____

_____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start?_____ How?_____
Is it ☐ getting better ☐ getting worse ☐ staying the same?
How would you describe the problem?_____
Are you taking medication for this condition? Y ☐ N ☐
If yes, which medication:_____Dose: ____
Please list ALL other medications you are currently taking:_____
_____
_____

PLEASE ELABORATE ON FURTHER COMPLAINTS ON A SEPARATE PAGE (IF NECESSARY)

Niverville
Family Chiropractic

PRESENT HEALTH CONCERNS- IN THE PAST 3 MONTHS, HAVE YOU BEEN AFFECTED BY ANY OF THE FOLLOWING? *Please check: O- Occasional F- Frequent C- Constant*

MUSCLE & JOINT	O	F	C
Backaches	☐	☐	☐
Neck Pain	☐	☐	☐
Painful Tailbone	☐	☐	☐
Foot Trouble	☐	☐	☐
Shoulder Pain	☐	☐	☐
Hernia	☐	☐	☐
Faulty Posture	☐	☐	☐
Arthritis	☐	☐	☐

STRESS SYMPTOMS			
Headaches/Migraines	☐	☐	☐
Dizziness	☐	☐	☐
Numbness in Arms/Hands	☐	☐	☐
Numbness in Legs/Feet	☐	☐	☐
Ringing in Ears	☐	☐	☐
Blurring of Vision	☐	☐	☐
Loss of Sleep	☐	☐	☐
Loss of Memory	☐	☐	☐
Irritable	☐	☐	☐
Depression	☐	☐	☐
Decreased Energy	☐	☐	☐
Tension	☐	☐	☐
Anxiety	☐	☐	☐
Nervous	☐	☐	☐

URINARY			
Painful Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in Urine	☐	☐	☐
Trouble Urinating	☐	☐	☐

RESPIRATORY	O	F	C
Chronic Cough	☐	☐	☐
Spitting Up Phlegm	☐	☐	☐
Spitting Up Blood	☐	☐	☐
Chest Pain	☐	☐	☐
Difficult Breathing	☐	☐	☐
Colds	☐	☐	☐

GASTROINTESTINAL			
Difficult Digestion	☐	☐	☐
Belching or Gas	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Stomach Pain	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Liver Trouble	☐	☐	☐
Gallbladder Pain	☐	☐	☐
Bloody Stool	☐	☐	☐
Heartburn	☐	☐	☐
Change of Appetite	☐	☐	☐

EYES, EARS, NOSE, THROAT			
Earache	☐	☐	☐
Sore Throat	☐	☐	☐
Asthma	☐	☐	☐
Tonsillitis	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sinus Infection	☐	☐	☐
Ear Infections	☐	☐	☐
Trouble Hearing	☐	☐	☐

CARDIOVASCULAR	O	F	C
Rapid Heart Beat	☐	☐	☐
Slow Heart Beat	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Pain Over Heart	☐	☐	☐
Swelling of Ankles	☐	☐	☐
Poor Circulation	☐	☐	☐
Previous Stroke	☐	☐	☐

GENERAL/NERVOUS SYMPTOMS			
Fever/Chills	☐	☐	☐
Fainting	☐	☐	☐
Skin Problems	☐	☐	☐
Convulsions	☐	☐	☐
Tremors	☐	☐	☐
Loss of Balance	☐	☐	☐
Allergy	☐	☐	☐

FEMALES ONLY	Y	N
Painful Menstruation	☐	☐
Irregular Cycle	☐	☐
Cramps & Backache	☐	☐
Excessive Flow	☐	☐
Abnormal Discharge	☐	☐
Menopause	☐	☐
Birth Control Pills	☐	☐

Date of last period: _____

PAST HEALTH- HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

	Y	N		Y	N		Y	N		Y	N
Thyroid Trouble	☐	☐	Emotional problems	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Pneumonia	☐	☐	Alcoholism	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Back pain	☐	☐	Stomach Ulcers	☐	☐	HIV/AIDS	☐	☐
Heart Disease	☐	☐	Headaches	☐	☐	Psoriasis	☐	☐	Asthma	☐	☐
Allergies	☐	☐	Epileptic Seizures	☐	☐	Polio	☐	☐	Tuberculosis	☐	☐
Other	☐	☐									

If so, please elaborate _____

PLEASE LIST ANY SIGNIFICANT ILLNESSES, OPERATIONS, ACCIDENTS, FALLS, OR TRAUMAS

DATE	ILLNESS/OPERATION/ACCIDENTS/FALLS/TRAUMAS

Niverville
Family Chiropractic

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166 Main Street,
Niverville, MB
204-388-6195

Consent to Chiropractic Adjustments and Care

It is important for you to consider the benefits, risks and alternatives to the options provided to you by your Doctor of Chiropractic. This will allow you to make an informed decision as you begin your chiropractic care in the office.

Chiropractic care includes adjustments and mobilization of the spine and other joints of the body. It may also include soft tissue techniques such as massage, and exercise.

Benefits

Chiropractic adjustments have been demonstrated to be effective for complaints of the back and other areas of the body caused by stress to the nerves, muscles, joints and related tissues. Adjustments and care by your Doctor of Chiropractic can also relieve pain including headaches, altered sensation, muscle stiffness and spasms. It can also increase mobility, improve sleep, improve function of the body so that you have more energy, support the immune system, support hormonal balance and reduce or eliminate the need for drugs and surgery.

Risks

As with any form of treatment there are always risks associated with it. The risks associated with chiropractic care vary according to each person's condition, as well as the location and type of treatment. A proper health history and evaluation procedures are used in the office to minimize any risk. However, some underlying challenges cannot be anticipated and may lead to some of the following risks

- While *rare*, some people may experience a temporary worsening of conditions. Usually, any increase in pre-existing symptoms of pain or stiffness will only last a few hours to a few days.
- While *rare*, some people may experience a muscle or ligament strain or sprain as a result of manual adjusting techniques. Although uncommon, rib fractures have also been known to occur. This will usually resolve itself within a few days or weeks with some rest and care.
- Over the course of a lifetime, spinal discs may degenerate or become damaged with normal daily activities such as bending or lifting. People with degenerated or damaged discs may or may not have symptoms. X-rays are taken so that we may provide the best care based on the health of your spine. There are rare reported cases of disc injuries following cervical and lumbar adjustments, although *no scientific evidence* has demonstrated such injuries are caused, or may be caused, by spinal adjustments of other chiropractic care.

- There are reported cases of strokes associated with visits to medical doctors and Doctors of Chiropractic. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of a stroke. Recent studies show that this association occurs very infrequently and is explained by the fact that the artery was already damaged and the person was progressing toward a stroke when they consulted the chiropractor. A thorough history and examination is performed in the office to ensure the best care for you is provided.

Alternatives

In some cases, alternatives to chiropractic care may be recommended. As Doctors of Chiropractic we may collaborate and consult other health professionals so that you get the best outcome. You may also receive exercises with or without chiropractic adjustments depending on your individual situation.

Questions or Concerns

You are part of the healing process and we encourage you to ask questions at any time regarding your care in our office. Bring any concerns you may have to our attention. You also have the right to stop your care at any time.

Please be involved in and responsible for your health care.
Inform your chiropractor immediately of any changes in your condition.

DO NOT SIGN UNTIL YOU HAVE MET WITH YOUR CHIROPRACTOR AND DISCUSSED YOUR CARE

I hereby acknowledge that I have read this consent and I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic care in general as well as the care options and recommendations for me. I have considered the benefits and risks of chiropractic care, as well as the alternatives. I hereby consent to chiropractic care recommended to me.

_____
Name (Please Print)

_____ Date_____20_____
Signature of Patient (or legal guardian)

_____ Date_____20_____
Signature of Chiropractor