Welcome to our office!
Intake

Norfolk Chiropractic – Adult

Please hand in your Manitoba Health Card at the front desk.

Patient Information:

Name_____
Address_____
City_____ Prov _____PC_____
Phone (H)_____(C)_____
E-mail _____
Date of Birth (D/M/Y)_____ Age ____
Emergency Contact_____
Relation_____ Phone_____

Occupation_____
Employer _____
Married □ Single □ Widowed □ Divorced □
Referred by_____
Family Doctor _____
Date of last physical _____
Is this an MPI (car accident) claim? Yes □ No □
Is this a WCB (workers comp.) claim? Yes □ No □

Current Condition: □ I am here for wellness and have no complaints *(Please skip to the next section)*

List your main complaints in order of severity:

1. _____ Duration?_____

Cause of Injury: _____

2. _____ Duration? _____

Cause of Injury: _____

3. _____ Duration? _____

Cause of Injury: _____

Pain is: Sharp □ Dull □ Achy □ Burning □ Numbing □ Tingling □ Constant □ Intermittent □

Pain interferes with: Work □ Sleep □ Routine □ Sport □ Pain scale (1 to 10)_____

Does your pain radiate (if yes to where?) _____

What activities aggravate your pain/condition? _____

What activities relieve your pain/condition? _____

Is the pain getting progressively worse? Yes □ No □ Is it worse at certain times of the day? _____

Is this the first time you've experienced this pain/condition?_____

Other treatments or home remedies _____

Previous Imaging: X-rays□ Bone Scan□ CT scan□ MRI□

Accidents/Trauma/Medical History:

Number of car accidents _____ Approximate Dates _____

List all surgeries and their dates_____

Medications _____

Falls/Accidents (including childhood)_____

Family medical conditions/history_____

Main hobbies and/or sports_____

Rate on a scale of poor, good or excellent: Exercise _____ Diet_____ Sleep_____ Health_____

Alcohol _____/week Caffeine _____/day Smoke _____packs/day Recreational Drugs_____/week

Rate your occupational stress (1-10, 10 being the most stressful)_____

Weight _____lbs *Height* ___' ___" *Hand Dominant* □ Right □ Left *Sleep Position* □ Back □ Stomach □ Side

Are you currently pregnant? Yes □ No □ Due date_____ Number of pregnancies_____

Chiropractic History:

Previous Chiropractor _____ When was your last visit?_____

Treated for_____ Did they take X-Rays? Yes □ No □

As a result of my chiropractic care, I would like to:

□ Feel better quickly □ Have a healthier spine and better postural alignment □ Have a better quality of life

Patient Signature: _____ Date: _____