thrive chiropractic

A New Healthcare Experience

NEW PATIENT HEALTH HISTORY

Today's Date: _____

Patient Data

Full Name: _____ Name of Preference: _____Sex: ☐ M ☐ F
Address: _____ City: _____ Prov:____ Postal Code: _____
Telephone: (Home)_____ (Cell)_____
E-mail: _____ ☐ (Do not send periodic info about holiday hours or special events)
Birth date: _____ (M/D/Yr) Age: _____ Occupation: _____
Marital Status: _____ Ages of Children (if applicable): _____
Have you been to a Chiropractor before? ☐ Yes ☐ No If yes, what year? _____
How did you find out about our office? _____
Manitoba Health Number (6 digits): _____ (9 digits): _____

About Your Health

Main **goal** in consulting our office:

- ☐ Corrective Care (Pain relief + restoration of spine and joint health)
- ☐ Maintenance/Wellness Care (Corrective Care + ongoing preventative care)
- ☐ Pain relief only (Not interested in corrective or wellness care)

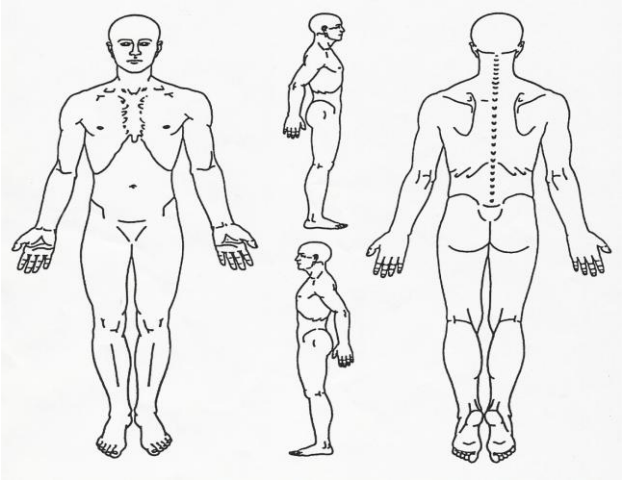
Main reason for consulting our office: Area(s) of complaint:_____

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 O=Other*) next to the area.

Please indicate **current level** of pain **next to each area:**
i.e. ___/10
(10 is the worst pain imaginable)



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:

_____

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

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 disease	☐ MS	☐ Menopause
☐ Constipation	☐ Sexual Dysfunction	☐ Numb/tingling legs	☐ Numb/tingling hands
☐ Cold hands/feet	☐ Diabetes	☐ Osteoporosis	☐ Skin disorder
☐ Frequent colds	☐ Arthritis	☐ 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	☐	☐	☐	☐	☐	_____

Vitals: (Used to complete your *Posture Screen* Assessment):

Height: _____ Weight:_____ Blood Pressure (if known) ☐ Low ☐ Normal range ☐ High

Events and Habits

Childhood and Adolescence	Yes	No	Date and/or pertinent details
Any notable falls?	☐	☐	_____
Any significant injuries or illnesses?	☐	☐	_____
Any surgeries or prolonged medications?	☐	☐	_____
Adulthood			
Past motor vehicle accident(s)?	☐	☐	_____
Slips or Falls?	☐	☐	_____

Hobby or sports injuries?	☐ ☐	_____
Smoke? Drink alcohol?	☐ ☐	_____
Exercise regularly?	☐ ☐	_____
Eat as healthy as you think you should?	☐ ☐	_____
Healthy weight?	☐ ☐	_____
Poor posture?	☐ ☐	_____
Sleeping posture:	☐ Side ☐ Back ☐ Stomach	
Approximate age of bed:	☐ _____	
Mental stress?	☐ Where on a scale of 0-10? **__/10**	
Repetitive strain?	☐ ☐	_____
Extended hours at a computer?	☐ ☐	_____

Consent for Communication/Release of Information

I hereby authorize/grant permission to Thrive Chiropractic to communicate with other health care professionals, insurance providers, and/or **MPI** (if applicable), and/or the **Worker's Compensation Board** (if applicable), with respect to my file or claim.

Signature(Patient or parent/guardian): _____ Date: _____

Exam and/or X-ray Consent for Men: I hereby consent to a chiropractic exam and X-ray evaluation (if necessary) to determine the most appropriate treatment plan.

Signature(Patient or parent/guardian): _____ Date: _____

Exam and/or X-ray Consent for Women: This is to certify that to the best of my knowledge I am not pregnant. I hereby consent to a chiropractic exam and X-ray evaluation (if necessary) to determine the most appropriate treatment plan. I understand that x-ray may cause harm to an unborn child.

Signature(Patient or parent/guardian): _____ Date: _____