thrive chiropractic

A new healthcare experience

NEW PATIENT HEALTH HISTORY

Today's Date: _____

Patient Data

Full Name: _____ Name of preference: _____

Sex: ☐ M ☐ F ☐ Transgender ☐ Non-binary Cell phone:(____)_____ Home/work:(____)_____

Address: _____ City:_____ Prov: _____ Postal code: _____

E-mail: _____ ☐ (Do not send periodic info about holiday hours or special events)

Birth date: _____ (M/D/Yr) Age: _____ Occupation: _____

Have you been to a Chiropractor before? ☐ Yes ☐ No If so, when/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 being here today:

_____

Is this a *Worker's Compensation Case (**WCB**)?* ☐ Yes ☐ No

If yes, date of injury? _____ Type of injury? _____Claim #_____

Name and phone number of *adjuster*? _____

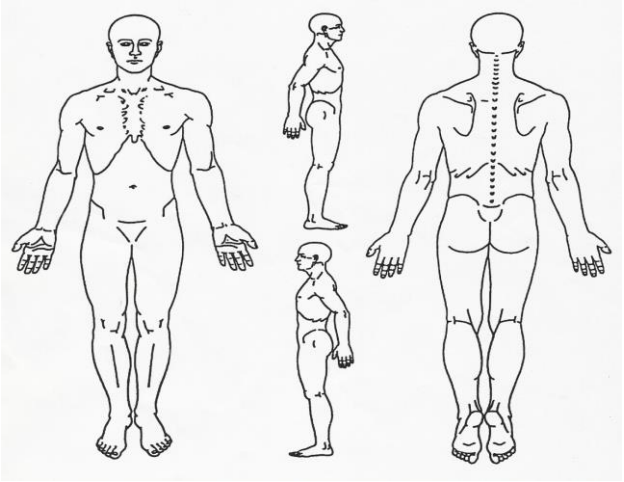
Did your complaint(s) arise from a *Motor Vehicle Accident (**MPI**)*? ☐ Yes ☐ No

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?

☐ Headaches	☐ Neck pain/stiffness	☐ Back pain/stiffness	☐ Loss of balance
☐ Dizziness or fainting	☐ High Blood Pressure	☐ Stroke	☐ Arthritis
☐ Numb/tingling hands	☐ Numb/tingling legs	☐ Seizures	☐ Thyroid disorder
☐ Sinus problems	☐ Asthma	☐ Poor concentration	☐ Osteoporosis
☐ History of Cancer	☐ Auto immune disease: _____	☐ Other:_____ _____	

Please list any current medications: (Please include oral contraceptives and over the counter products)
_____

Any major surgeries: (please include type of surgery and year) _____

Vitals: (Used to complete your *Posture Screen* Assessment):
Height: _____ Weight:_____ Blood Pressure (if known) ☐ Low ☐ Normal range ☐ High

Events and Habits

	Yes	No	
Past motor vehicle accident(s)?	☐	☐	_____
Any notable falls where injury occurred?	☐	☐	_____
Hobby or sports injuries?	☐	☐	_____
Smoke? Drink alcohol?	☐	☐	_____
Exercise regularly?	☐	☐	_____
Healthy weight?	☐	☐	_____
Poor posture?	☐	☐	_____
Sleeping posture:	☐ Side	☐ Back	☐ Stomach
Approximate age of bed:			_____
Mental stress?	☐	☐	If so, where on a scale of 0-10? **___/10**
Repetitive strain?	☐	☐	_____
More than 5 hours at a computer/day?	☐	☐	_____

Consent for Communication and Examination

1- 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.

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

2- Consent for **Examination and/or X-ray** Study (please sign section a or b):

Consent for Exam and/or X-ray **for Men:**

a) I hereby consent to a chiropractic examination and X-ray evaluation (if necessary) to determine the most appropriate treatment plan.

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

OR

Consent for Exam and/or X-ray **for Women:**

b) This is to certify that to the best of my knowledge I am not pregnant. I hereby consent to a chiropractic examination 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.

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