SUN CHIROPRACTIC

PATIENT INTAKE FORM (PLEASE FILL OUT COMPLETELY AND SIGN)

Name: ______________________________ Sex: M F DOB: ____________ Age: ________

First Middle Initial Last D M Y

Address: ______________________________ Postal Code: ____________

Home Phone: ____________ Cell: ____________ Business: ____________

Email: ______________________________ Occupation: ____________

Employer: ____________ Referred to Office By: ____________

Have you had Chiropractic care before? Y N When? ____________

By Whom? ____________ When was you last x-ray? ____________

Manitoba Health Registration#: ____________ Private Insurance # ____________

Are you Claiming under: ☐ WCB ☐ MPIC Claim #: ____________

Current Medical Doctor: ____________ Women: Are you or could you be pregnant? Y N

Are you current taking any medication? If so what? ____________

Have you had any recent falls or injures? Explain: ____________

Have you had any recent surgery? Explain: ____________

Please describe any specific health problems and what brings you in for this consultation: ____________

DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?(PLEASE CIRCLE)

Headaches
Sensitivity to light
Sensitivity to noise
Dizziness
Double vision
Trouble swallowing
Trouble speaking
Fainting
Poor balance
Numbness/tingling
Nausea

Jaw pain
Neck pain
Mid back pain
Low back pain
Arm pain
Painful joints
Fatigue
Chest pain
Heart racing
Shortness of Breath
Depression

Constipation
Trouble sleeping
Joint pain

GENERAL HEALTH

Arthritis
Allergies
Hyperthyroid
Hypothyroid
Diabetes
Asthma
Cancer

High blood pressure
Low blood pressure
Heart disease
Stroke
Ulcers
HIV
Hepatitis

WOMEN

Menstrual cramps
Menstrual irregularity

To the best of my knowledge the above is complete and accurate. I give Sun Chiropractic and it's representatives permission to communicate with me via the above contact information including electronic communication.

★ Signature: ______________________________ Date: ______________________________