KENASTON FAMILY CHIROPRACTIC

1869 Grant Ave
Winnipeg, MB R3N 1Z2
Ph. (204) 488-2777

PATIENT APPLICATION

Name: _____ Gender M F Age: _____

Home Address: _____ Home Phone: _____

City, Province: _____ Work Phone: _____

Postal Code : _____ Cell Phone: _____

Birth Date (MM/DD/YY): _____ / _____ / _____ Manitoba Health (6 digit): _____

Marital Status: S M D W Manitoba Health (9 digit) _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ _____

Name of Children: _____

How did you hear about our office? Internet ___ Advertising ___ Sign ___ Patient:_____

Is this Autopac (MPI) or WCB (Worker's Compensation): YES NO
If yes, Accident / Injury Date: _____ Personal Injury claim # _____

May we contact you by email? YES NO Email: _____

PURPOSE OF THIS VISIT

What brings you in today? _____

On a scale of 1-10 (10 being the worst), how bad is the problem? _____

How long have you had this problem? _____

How did this problem start? _____

What is the pattern of this problem? __ Constant, __ Intermittent, __ Occasional, __ Cyclic

What activities aggravate your symptom? _____

Are your symptom worse in the: AM PM

What gives you some temporary relief? _____

Type of pain (please circle): Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain go into your: Arm Leg No Is this condition getting worse? Yes No

Have you had this condition before? Yes No If so, please explain:_____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

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Are there other concerns?

Condition 2: _____

In scale of 1-10 (10 being severe), how bad is the problem? _____

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? YES NO

If yes, which medication? _____ Dose: _____

Condition 3: _____

In scale of 1-10 (10 being severe), how bad is the problem? _____

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? YES NO

If yes, which medication? _____ Dose: _____

HEALTH CONDITIONS

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Does anyone in your family suffer with the same condition(s) / complaint(s)? Yes No, if yes, whom:_____
Which condition? _____

Any other conditions the doctor should be know: _____

SIGNATURE: _____ DATE: _____

Signature of Parent/Guardian required if patient is under the age of 18

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YOUR HEALTH HISTORY

Please mark 'X' for present conditions, 'O' for past condition:

__ Migraine
__ Headache
__ Neck Pain
__ Jaw Pain / TMJ / RJ
__ Numb / Tingling in hand / arm
__ Upper Back Pain
__ Shoulder pain
__ Mid Back Pain
__Low Back Pain
__ Hip Pain
__ Numb / Tingling in leg / feet
__ Foot Pain
__Scoliosis
__ Arthritis
__ Diabetes
__Swollen / Painful Joints
__ Frequent Colds / Flu
__ Cancer
__Convulsions / Epilepsy
__ Chest Pain
__Skin Problems
__High Blood Pressure
__ Low Blood Pressure
__ Colon Trouble
__Heart Trouble
__ Stroke
__ Gall Bladder Trouble
__Depression
__ Irritable
__ Varicose Veins
__ Mood Changes
__ Anemia
__ Asthma
__ Tremors
__ Allergies
__ Ear Infection
__ Heartburn
__ Impotence
__ Ulcers
__ Sexual Dysfunction
__ Prostate Problems
__ Loss of Balance
__ PMS
__ Menstrual Problem
__ Hearing Loss
__ Menopausal Problems
__ Bed Wetting
__ Dizziness
__ Hepatitis (A,B,C)
__ HIV / AIDS
__ ADD / ADHD
__ Sinus Problems
__ Eating Disorders
__ Diarrhea / Constipation
__ Trouble Sleeping
__ Digestive Problems
__ Liver Trouble
__ Learning Disability
__ Breathing Problems
__ Double Vision
__Ringing in Ears
__ Kidney Trouble
__ Blurred Vision
__ Fainting

SIGNATURE: _____ DATE: _____

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