PATIENT INTRODUCTION FORM (PLEASE FILL OUT COMPLETELY)

Name: First Middle Initial Last

Sex: for insurance purposes

DOB: D M Y

Age:

Address:

Postal Code:

Home Phone:

Cell:

Business:

Email:

Occupation:

Employer:

Number of Dependants:

Marital Status:

Referred to Office by:

Have you had Chiropractic care before? When?

When was your last xray?

By Whom?

Manitoba Health Registration#:

Private Insurance #:

Are you Claiming under: MPI ☐ ☐ WCB Claim #:

Current Medical Doctor:

Women: Are you or could you be pregnant?

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 representative permission to communicate with me via the above contact information.

Signature:

Date: