Mommy&Me
Family Chiropractic

Today's Date:_____

Patients name : _____ Referred by: _____
Home Address: _____DOB:_____
Postal code: _____ Province:_____ City:_____
Phone:(H)_____(C)_____ (W)_____
E-mail Address: _____
Occupation: _____Marital Status: ☐S ☐M ☐ D ☐ W
Spouses Name: _____Phone #:_____
No. Weeks Pregnant: _____ Approximate Due Date: _____
No. of children and ages:_____
Manitoba Health Registration No. _____ PHIN # : _____

Chiropractic History

Have you previously seen a chiropractor? ☐Y ☐N If yes, with whom? _____
If Yes, when was your last visit and how long was treatment?_____
Have you ever had x-rays taken? ☐Y ☐N If yes, when and where? _____

Current Health Condition

☐ *I'm for wellness and have no complaints (Please skip this section)*

Reason for today's visit? _____
When did it start?_____ Why do you think it started?_____
How has your condition/pain been progressing: ☐ getting worse ☐ better ☐ staying the same
Does anything make your condition/pain better? _____
Does anything make your condition/pain worse? _____
Is your condition/pain worse during certain times of the day? _____
Rate your pain/ discomfort on a scale of 0-10 with 0 being no pain/discomfort and 10 being the worst pain/ discomfort imaginable: At It's best: _____At It's worst: _____ Currently:_____
Are you experiencing any other signs/symptoms that go along with your main concern? ☐Y ☐N If yes, please explain:_____
Have you seen anyone else for this complaint? ☐Y ☐N If yes, with whom? _____
What were the results? _____
What was the treatment? _____
Are you currently using any home remedies? _____

Please check all symptoms you are currently experiencing:

□ Headaches	□ Tension	□ Double Vision	□ Shortness of	□ IBS / Crohn's
□ Neck Pain	□ Irritability	□ Loss of Memory	Breath	□ Multiple Sclerosis
□ Sleeping Problems	□ Chest Pains	Pins & Needles in:	□ Fatigue	□ Leg / Calf cramps
□ Back Pain	□ Dizziness	□ Legs □ Arms	□ Depression	□ Pubic Pain
□ Nervousness	□ Face Flushed	□ Fingers □ Toes	□ Light Bothers Eyes	□ Swelling
□ Ears Ring / Buzz	□ Loss of Smell	□ Diarrhea	□ Nausea	□ Asthma
□ Fever	□ Loss of Taste	□ Cold Feet	□ Constipation	□ Allergies
□ Fainting	□ Difficulty	□ Cold Hands	□ Loss of Balance	□ Frequent colds/flu
□ Cold Sweats	Swallowing	□ Upset Stomach	□ Ear Infections	Other:_____

Birthing Information

Who are your chosen birth attendants: □ Midwife □ Obstetrician □ Doula □ Chiropractor

Chosen location of birth: □ Hospital □ Birthing Center □ Home

How active is your baby? □ Not moving at all □ Slow but moving □ Active □ Very active □ Other:_____

If you have had a previous pregnancy did you have or experience any of the following with your labor:

□ Hospital birth □ Home birth □ Birthing centre □ Other birth location □ Epidural □ Episiotomy □ Induction

□ Breech presentation □ Back labor □ Forceps □ C-section □ Vacuum extraction □ Fetal scalp monitoring

Accidents/Traumas/Injuries

No. of car accidents: _____ Approximate dates: _____

Any Injuries/ broken bones? ☐Y ☐N If yes, please explain _____

Any Hospitalizations? ☐Y ☐N If yes, please explain _____

Any Surgeries? ☐Y ☐N If yes, please explain: _____

Please list any medications you are currently taking: _____

Current Health

How often would you say you engaged in physical activity: ☐ 0x/wk ☐1-3x/wk ☐ 4-7x/wk

How would you describe your diet: ☐ Poor ☐Fair ☐Good ☐Excellent

Do you smoke? ☐Y ☐N How many cigarettes per day? _____

Do you drink alcohol? ☐Y ☐N How many drinks per week? _____

Are you currently taking any prescribed or OTC medications? ☐Y ☐N If yes, please list: _____

_____

What are your health goals? _____

<u>As a result of my chiropractic care, I would like to: (Please check all that apply)</u>

□ Feel better quickly □ Have a healthier spine and nervous system □ Better postural alignment

□ Improved function and performance □ Have a better quality of life

Signature: _____ **Date:** _____