Mommy&Me
Family Chiropractic

MPI Health History **Today's date**:_____

Patients Name :_____ Referred by:_____
Home Address:_____
Postal code:_____ City:_____Province:_____
Phone:(H)_____ (C)_____ (W)_____
E-mail Address:_____Occupation:_____
Marital Status: S M D W Spouses Name:_____
Date of Birth:_____Occupation:_____
MPI Claim No._____Date of the accident:_____

How did the accident happen:_____
_____
_____

Were you the: □ driver □ passenger **Did the air bags go off?** □Yes □ No
Were you wearing your seatbelt? □Yes □ No **Did you brace yourself ?** □Yes □ No **If yes, how so?**
_____

Were you surprised by the impact? □Yes □ No **Did you collide with another car?** □ Yes □ No
Did you roll the car? □ Yes □ No
Where did the impact take place? □ Drivers side □ Rear end □ Front □ Passenger
Were you leaning forward at the time of impact? □ Yes □ No
Was your head or body turned? □ Yes □ No If yes, which way:_____
What was the speed of your vehicle when the accident occurred? _____ **Km**
Speed of the other vehicle? _____**Km**
Were you rendered unconscious? □ Yes □ No **Were you taken to the hospital?** □Yes □ No **If yes, how long were you there?**_____ **Did they take x-rays?** □Yes □ No
Did you feel pain immediately after the accident? □ Yes □ No
What are your major complaints/symptoms stemming from the accident?
_____
_____

Have you been in an accident before? □Yes □ No **If so, when**?_____

In the 5 years prior to the collision, have you:

Taken time off work for more than 4 weeks because of a previous injury or health problem? □ Yes □No
If yes, please explain: _____
Use prescription or OTC medication on a regular basis? □ Yes □ No **If yes, type and reason?**
_____

Experience any significant health problems requiring ongoing care? □ Yes □ No **If yes, please explain:**

_____

Receive any chiropractic or physiotherapy sessions? □ Yes □ No **If yes, date of last treatment**:

_____ **Did they take x-rays?** □Yes □ No

Please check all other symptoms you are currently having:

□ **Headaches**	□ **Fatigue**	□ **Cold Hands**
□ **Neck Pain/Stiffness**	□ **Depression**	□ **Stomach Upset**
□ **Sleeping Problems**	□ **Light Bothers Eyes**	□ **Nausea**
□ **Back Pain**	□ **Double Vision**	□ **Constipation**
□ **Nervousness** □ **Tension**	□ **Loss of Memory**	□ **Loss of Balance**
□ **Irritability**	□ **Ears Ring/Buzzing**	□ **Ear Infections**
□ **Chest Pains**	□ **Fever**	□ **Asthma**
□ **Dizziness**	□ **Fainting**	□ **Allergies**
□ **Face Flushed**	□ **Cold Sweats**	□ **Frequent Colds/Flu**
□ **Pins & Needles in Legs**	□ **Loss of Smell**	□ **Menstrual problems**
□ **Pins & Needles in Arms**	□ **Loss of Taste**	□ **IBS/Crohn's disease**
□ **Numbness in Fingers**	□ **Difficulty Swallowing**	□ **Anxiety**
□ **Numbness in Toes**	□ **Diarrhea**	□ **Multiple Sclerosis**
□ **Shortness of Breath**	□ **Cold Feet**	

Other conditions, diseases or concerns:_____

_____

Work Status

Are you currently working? □ Yes □ No **If no, indicate target return date**:_____

Will a return to work worsen your condition? □ Yes □ No _____

Does your condition affect your ability to travel to and from the workplace? □ Yes □ No

Does your condition result in an inability to perform required tasks? □ Yes □ No

Does your condition pose a safety/health risk to yourself or your co-workers? □ Yes □ No

Accidents/Injuries/Hospitalizations

Have you had any work, sports or other injuries:

_____

Have you had surgery? □ Yes □ No **What type and when** ?_____

Any significant family medical conditions/history?_____

Are you currently taking any prescribed or OTC medication? □ **Yes** □ **No If yes, please explain**:_____

Signature:_____ **Today's Date:**_____