

**MPI Health History**

**Welcome To Family First Chiropractic**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Prov \_\_\_\_\_ PC \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)  
Referred By \_\_\_\_\_

Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Marital Status            S            M            D            W  
Spouse's Name \_\_\_\_\_  
No. of children \_\_\_\_\_  
Manitoba Health registration # \_\_\_\_\_  
MD's Name \_\_\_\_\_

**Chiropractic History**

Have you previously seen a chiropractor?    Yes  No  Reason \_\_\_\_\_ Did they take x-rays?    Yes  No   
If yes, when was your last visit and how long did you receive care \_\_\_\_\_

**Current Health Condition**

*I'm here for wellness and have no complaints*  *(Please skip to the next section)*

Reason for today's visit \_\_\_\_\_

Pain or problem started on \_\_\_\_\_ Why do you think the problem/pain started? \_\_\_\_\_

Pain is:    Sharp     Dull     Constant     Intermittent     Pain is interfering with:    Work     Sleep     Routine     Other \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is it worse during certain times of the day? \_\_\_\_\_ Is this condition getting progressively worse?    Yes     No

Other Doctors seen: \_\_\_\_\_ Any home remedies? \_\_\_\_\_

**Other symptoms:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Ear Infections                     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Cold Sweats     | <input type="checkbox"/> Asthma                             |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Allergies                          |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Frequent colds/flu                 |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Menstrual problems                 |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Feet Cold       | <input type="checkbox"/> IBS / Crohn's disease              |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Depression             | <input type="checkbox"/> Hands Cold      | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Light Bothers Eyes     | <input type="checkbox"/> Stomach Upset   | <input type="checkbox"/> Multiple Sclerosis                 |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Loss of Memory         | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Other Conditions or diseases _____ |
| <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Ears Ring              | <input type="checkbox"/> Loss of Balance |   |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Buzzing in Ear  |   |

**Accidents/Trauma/Injury History**

Number of car accidents: \_\_\_\_\_ Approximate dates: \_\_\_\_\_

Any work, sports or other injuries: \_\_\_\_\_

Any medications you are currently taking: \_\_\_\_\_

Have you had surgery?    Yes     No     What type? \_\_\_\_\_    When? \_\_\_\_\_

Any significant family medical conditions/history: \_\_\_\_\_

Give a brief description of the physical nature of your work: \_\_\_\_\_

Rate your occupational stress (1-10, 10 being the most stressful) \_\_\_\_\_

What types of physical, emotional and chemical stressors have you experienced \_\_\_\_\_

Do you smoke?    Yes     No     How many per day? \_\_\_\_\_    Do you drink alcohol?    Yes     No     How many per week? \_\_\_\_\_

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

- Feel better quickly     Have a healthier spine     Live a healthier lifestyle     Have a healthier body by keeping my nervous system healthy

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Auto Accident Mechanism of Injury**

Date of Accident \_\_\_\_\_

MPI Personal Claim Number \_\_\_\_\_

Please describe how the accident happened

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you surprised by the impact? Yes  No

Did you brace yourself? Yes  No

Did you collide with another car or object? Yes  No

Where did the impact take place? Drivers side  Rear end  Front  Passenger

Did you roll the car? Yes  No

In relation to the back of your head, was your headrest set: Low  Middle  High

Were you leaning forward at the time of impact? Yes  No

What was the speed of your vehicle when the accident occurred? \_\_\_\_\_

What was the speed of the other vehicle when the accident occurred? \_\_\_\_\_

Were you rendered unconscious? Yes  No

Did you feel pain immediately after the accident? Yes  No

Please describe any treatment or tests undergone after the accident.

\_\_\_\_\_  
\_\_\_\_\_

Have you been in an accident before, If so when?

\_\_\_\_\_  
\_\_\_\_\_

What are your major complaints/symptoms stemming from the accident?

\_\_\_\_\_  
\_\_\_\_\_

What symptoms (if any) were you experiencing prior to the accident?

\_\_\_\_\_  
\_\_\_\_\_

**In the 5 years prior to the collision, did you:**

Take time off work more than 4 weeks because of a previous injury or health problem? Yes  No

Use prescription or OTC medication on a regular basis? Yes  No

Experience any significant health problems requiring ongoing care? Yes  No

Receive any chiropractic or physiotherapy sessions? Yes  No

If yes, list date of last treatment: \_\_\_\_\_

Experience any problems with anxiety, depression or substance abuse? Yes  No

**Work status:**

Occupation: \_\_\_\_\_

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

Signature \_\_\_\_\_

Date \_\_\_\_\_