

CONFIDENTIAL HEALTH QUESTIONNAIRE

Date: _____

Name (According to MB Health Card): _____
(FIRST) (MIDDLE) (LAST OR SURNAME)

Phone #: Home _(_____) _____ Cell _(_____) _____

Parent (If under 18) _(_____) _____ Spouse _(_____) _____

Name of Parent (If under 18): _____ Name of Spouse: _____

Address (According to MB Health Card): _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____ Occupation/Profession: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: M F 6 Digit REG #: _____
(MONTH) (DAY) (YEAR) 9 Digit PHIN #: _____

Name of Medical Doctor: _____ Who referred you to us? _____

History of Present Health:

Have you been treated by a chiropractor before? YES or NO If yes, by whom? _____

When? _____ If this year, how many visits did you have there? _____

Previous Treatment:

What Treatment For This Current Condition Have You Had Prescribed:

a. Recently? _____

b. In The Past? _____

Have you been X-rayed during the last 12 months? YES _____ NO _____

History of Past Health/Past Illnesses:

Do You Have A History Of: (Circle which apply)

Back Pain | Neck Pain | Upper Extremity Pain | Lower Extremity Pain | Any Other Musculoskeletal Pain

Significant Health Illnesses:

Please List Any Significant Health Illnesses You've Had In The Past:

Cancer, Tumour, Diabetes, Thyroid, Aneurysm, Stroke, Heart Attack, Other: _____

Significant Accidents or Falls: Please List: _____

Any Operations, Or Surgery: Please List: _____

Current Medical Management: Are You Currently Being Treated For Any Other Health Problems? YES or NO

If yes, please list: _____

All Medication/Herbs/Vitamins You Are Currently Taking: Please List: (If you have them listed, we can make a photocopy)

Family History: Do You Have Any Significant Family History Of Other Health Problems? Please List: _____