TRANSCONA CHIROPRACTIC WELLNESS CENTRE
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Patient Health Questionnaire

Name: _____ Date: _____

Address: _____
Street Address City Province Postal Code

Cell Number: (____) _____ Work Number: (____) _____

Home Number: (____) _____

Email: _____

Manitoba Health Number: (6 digits) __ __ __ __ __ __ (9 digits) __ __ __ __ __ __ __ __ __

Date of Birth: (DD/MM/YYYY): _____ Age: _____

Male: ☐ Female: ☐ Other: ☐

Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Spouse's Name: _____

Number of Children: _____

Occupation: _____ Employed By: _____

Have you ever had previous chiropractic care: Yes ☐ No: ☐

If Yes, what was the Chiropractor's name: _____

Medical Doctor's Name & Phone Number: _____

Who may we thank for referring you to our office? _____

Do you have an active claim with MPI? Yes ☐ No: ☐

- Date of Injury: _____ Injury Claim #: _____

Do you have an active claim with WCB? Yes ☐ No: ☐

- Date of Accident: _____ Injury Claim#: _____

1. **<u>What is your main reason for consulting our office?</u>**

_____
_____
_____
_____
_____

2. **<u>Health information:</u>**

If you are experiencing pain, is it:

Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Radiating ☐

Since the problem started, it is:

About the Same ☐ Getting Better ☐ Getting Worse ☐
What makes it worse: _____

How frequent is the complaint? Constant ☐ Daily ☐ Intermittent ☐ Night Only ☐

How long does it last: All Day ☐ A Few Hours ☐ Minutes ☐

Is there anything you do to try and relieve the problem? Yes ☐ No: ☐
If yes, please describe: _____

It interferes with: Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐

0 1 2 3 4 5 6 7 8 9 10
Least Most

Please mark an X on the line above to indicate your problem level.

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

☐Headaches	☐Pins & Needles in Legs	☐Fainting	☐Neck Pain
☐Loss of Smell	☐Pins & Needles in Arms	☐Back Pain	☐Loss of Balance
☐Dizziness	☐Buzzing in Ears	☐Ringing in Ears	☐Nervousness
☐Numbness in Fingers	☐Numbness in Toes	☐Loss of Taste	☐Upset Stomach
☐Fatigue	☐Depression	☐Irritability	☐Tension
☐Sleeping Problems	☐Stiff Neck	☐Cold Hands	☐Cold Feet
☐Diarrhea	☐Constipation	☐Fever	☐Hot Flashes
☐Cold Sweats	☐Sensitive Eyes	☐Problems Urinating	☐Heartburn
☐Mood Swings	☐Menstrual Pain	☐Menstrual Irregularity	☐Ulcers

Please note any major illnesses you have had: Heart Disease ☐ Cancer ☐ Diabetes ☐
Other: _____

Please list any major accidents or surgeries you have had:

_____

_____

Please list any medication you are taking:

_____

_____

On a scale of POOR, GOOD OR EXCELLENT, DESCRIBE YOUR:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

If you have no symptoms or complaints, and are here for wellness services, please check (√) here: _____.

- If you have symptoms or complaints, please briefly describe the chief area of complaint, including the affect it has had on your life, when you first noticed it, and how it originally occurred.

_____

_____

_____

For female patients: Are you pregnant or is there any possibility of you being pregnant:

Yes: ☐ No: ☐

Notice: Not all patients require X-Rays to determine or verify a diagnosis, type, and length of care. However, if your examination warrants X-Ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for X-Rays is for analysis only. The film itself is the property of this office and cannot be released.

Please note: Patients have the right to discontinue care at any time without penalty. However, patients are obligated to pay all outstanding balances on their accounts.