TRANSCONA CHIROPRACTIC WELLNESS CENTRE
1783 Plessis Rd, Unit 7, Winnipeg, Manitoba, R3W-1N3
Ph: 777-WELL (9355) Fax: 777-9356
Email: drduggal@transconachiropractic.com
www.transconachiropractic.com

Patient Health Questionnaire

Name:_____ Age: _____ Today's Date: _____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

Cell Phone Number: ( )_____ Email: _____

Manitoba Health Number: 6 digit _____ 9 digit _____

Birth date:_____ _____ Male: __ Female: __

Occupation: _____ Employed by:_____

Your main reason for consulting our office is: _____

Single: ___ Married: ___ Divorced:____ Widowed: ___ Spouse's Name: _____

Number of children: _____ Names of children: _____

Have you had previous chiropractic care? (circle one) Yes No Chiropractor's name: _____

Medical Doctor's name and phone number: _____

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

Do you have an active claim with MPIC? ☐Y ☐N Date of Injury? _____

Do you have an active claim with WCB? ☐Y ☐N Date of accident? _____

The Beginning Years (ages 17 and below)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	___	___	___
Did you have any serious falls as a child?	___	___	___
Did you play youth sports?	___	___	___
Did you take/use any drugs? _	___	___	___
Did you have any surgery?	___	___	___
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	___	___	___
Were you involved in any car accidents as a child?	___	___	___

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	___	___	___
Did you suffer any other traumas? (physical or emotional)	___	___	___
Were you vaccinated?	___	___	___
As a child, were you under regular Chiropractic care?	___	___	___

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Adult Years (Ages 18 to present)

	YES	NO
Do/did you smoke?	____	____
Do/did you drink alcohol?	____	____
Have you been in any accidents?	____	____
Have you had any surgery?	____	____
Do/did you participate in extreme sports?	____	____
Do/did you play any adult sports?	____	____

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 occured.

_____

_____

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 can do to relieve the problem? ☐ Yes ☐ No If yes 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
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ 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	☐ Problem Urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

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

_____

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Please list any major accidents or surgeries you have had: _____

_____

Please list any medications you are taking: _____

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.