PATIENT INTAKE FORM

JEFFERSON CHIROPRACTIC CENTRE
2055 McPhillips St., Unit 3, Winnipeg, MB, R2V 3C6
jeffersonchiropractic@gmail.com, 204 334 6303

DR. CARLOS P. TAVARES

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH D/M/Y
ADDRESS	POSTAL CODE	HOME PHONE	CELL PHONE
EMAIL ADDRESS	EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP
9 DIGIT MB. HEALTH NUMBER (PHIN#)		6 DIGIT MB. HEALTH NUMBER (REGISTRATION #)	
OCCUPATION	EMPLOYER	WORK PHONE	ADDRESS
GENDER		HOW DID YOU HEAR ABOUT US?	

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR?		YES	DOCTOR'S NAME	ADDRESS
		NO		

DATE OF LAST APPT.	DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE LIST	ARE YOU PREGNANT?		YES	DUE DATE
				NO	

ARE YOU MAKING A CLAIM FOR:		AUTOPAC	CLAIM#
		WORKER'S COMPENSATION ACT	CLAIM#
		NO	

HAVE YOU HAD ANY FALLS, ACCIDENTS OR INJURIES? IF YES PLEASE EXPLAIN (PROVIDE MONTH/YEAR)		YES		NO
HAVE YOU HAD ANY SURGERY? IF YES PLEASE EXPLAIN (PROVIDE MONTH/YEAR)		YES		NO
ARE YOU TAKING ANY MEDICATION? IF YES PLEASE GIVE TYPE, DOSAGE, AND WHAT IT IS FOR.		YES		NO
ANY FAMILY HEALTH CONDITIONS OR PROBLEM? PLEASE LIST:		YES		NO
DO YOU TAKE ANY VITAMINS AND MINERALS? PLEASE LIST:		YES		NO

PATIENT HEALTH HISTORY

PLEASE CHECK ALL CONDITIONS AND SYMPTOMS - (C) CURRENT AND (P) PAST THAT YOU HAVE EXPERIENCED:

C	P	GENERAL SYMPTOMS
		Loss Of Consciousness
		Blackouts
		Loss Of Sleep
		Fever
		Nervousness
		Weight loss
		Sweats
		Headaches
		Convulsions
		Dizziness
		Fainting
		Clumsiness
		Numbness & Tingling
C	P	EYE EAR NOSE THROAT
		Blurred vision
		Failing vision (one,both eyes)
		Crossed eyes
		Double vision
		Eye pain
		Deafness
		Ear ache
		Ringing, buzzing/noise in ears
		Asthma
		Frequent colds
		Sinus infection
		Enlarged glands
		Enlarged thyroid
		Slurred or other speech problems
		Difficulty swallowing
C	P	MUSCLES & JOINTS
		Sore/stiff neck
		Back ache
		Swollen Joints
		Painful Tailbone
		Ankle/foot Trouble
		Shoulder pain
		Elbow pain
		Wrist pain
		Hand pain
		Hip pain
		Knee pain
		Arthritis
		Weakness or loss of strength
C	P	RESPIRATORY
		Chest pain
		Chronic cough
		Difficulty breathing
		Spitting up phlegm
		Spitting up blood
C	P	GENITOURINARY
		Trouble urinating
		Blood in urine
		Kidney infection
		Bed wetting
		Prostrate trouble
C	P	SKIN
		Rashes, itching
		Bruise easily
		Dryness
		Boils
		Hives (allergy)
C	P	CARDIOVASCULAR
		Bleeding disorder
		High blood pressure
		Chest pain
		Stroke
		Hardening of arteries
		Ankle swelling
		Poor circulation
		Heart/blood disease
		Angina
C	P	GASTROINTESTINAL
		Poor appetite
		Indigestion
		Excess hunger
		Belching or gas
		Nausea
		Vomiting
		Pain over stomach
		Constipation
		Diarrhea
		Hemorrhoids
		Jaundice
		Gallbladder trouble
C	P	GU FOR WOMEN
		Painful menstruation
		Excessive flow
		Hot flashes
		Irregular cycle
		Cramps or backache
		Vaginal discharge
		Swollen breasts
		Lumps in breasts
		Miscarriage

Y	N	HEALTH QUESTIONS
		Have you every been on birth control pills?
		Are you currently taking birth control pills?
		Have you every had any fractures?
		Have you ever been in a car accident?
		Have you ever been hospitalized?
		Have you every smoked?
		Do you currently smoke?
		Have you every been diagnosed with cancer?
		Have you tested positive for AIDS?

CHIROPRACTIC CARE

Please List Your Reasons For choosing chiropractic care:

How Long Have You Had This Condition?

Is it Getting: BETTER WORSE NOT CHANGING

Have You Tried Any Other Treatment For This Condition?

What activities aggravate your condition/pain?

What activities lessen your condition/pain?

Is this condition worse during certain times of the day?

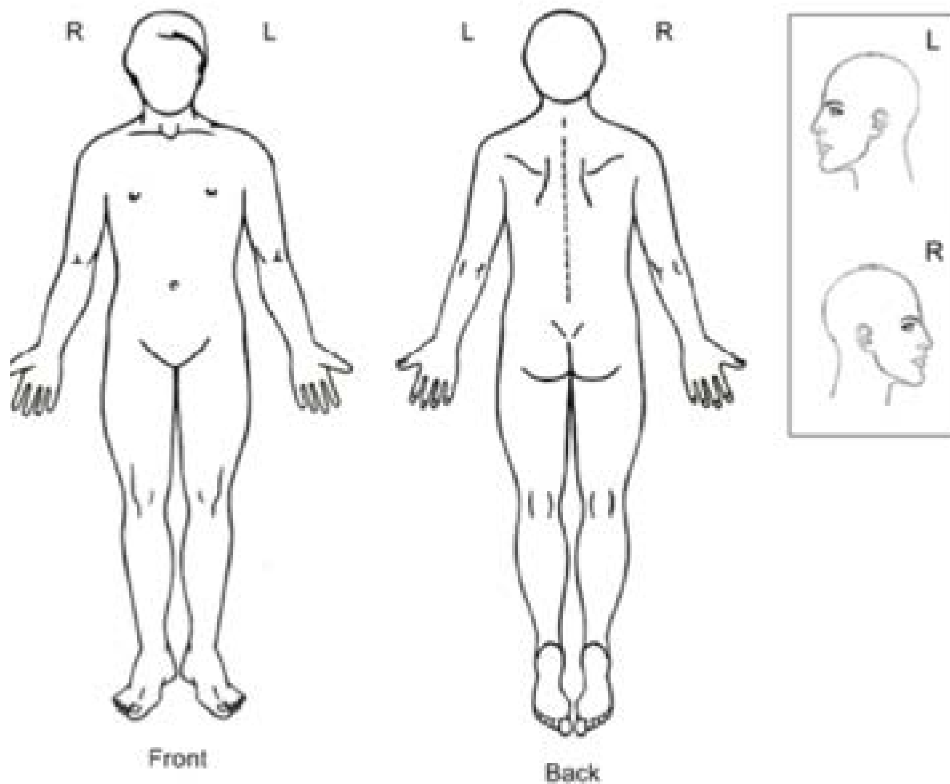
Is this condition interfering with:

WORK SLEEP ROUTINE OTHER

PRIMARY AREA OF PAIN

Where is the primary area of your pain?
Describe the pain (tingling, numb, sharp, etc.)
Rate your pain 1-10, 10 being worst
Please provide any other details:

INDICATE ON THE DRAWING BELOW WHERE YOU HAVE PAIN/SYMPTOMS



WE ARE DEDICATED TO PROVIDE YOU WITH EXCELLENT CHIROPRACTIC CARE FOR YOUR WHOLE FAMILY.

I understand that the charges for chiropractic services may not be covered by or may exceed my insurance policy benefits. I understand that I am financially responsible to the provider of chiropractic service for the cost of the treatment. Further, I understand that payment is expected at time of visit unless prior arrangement has been made with the provider.

Signature of patient/guardian

Date d/m/y