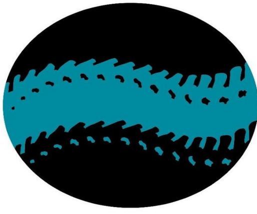


HANOVER CHIROPRACTIC & MASSAGE THERAPY

Patient Intake Form

MB Health **# (6)** ______________________ MB Health PHIN **# (9)** ______________________ AGE ________

NAME ______________________________________ DATE OF BIRTH (D/M/Y) ______________________

ADDRESS ______________________________________ PHONE ______________________

CITY/TOWN______________________POSTAL CODE______________ CELL ______________________

EMAIL ______________________________

Have you had previous chiropractic care? Yes No

When? (Month)____________(Year)______ Doctor/Clinic: ______________________

What were you treated for? ______________________________________

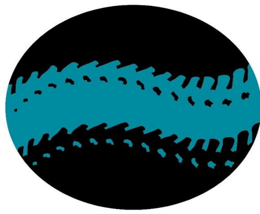
Have you had X-rays? Yes No

Do you have a Health Insurance Policy? Yes No Company Name: ______________________

Occupation:______________________ Gender:______________

Main Complaint:
How did it start?
When did it start?
How often do you feel it (25% of the time, half the day, all day)?
Does it radiate anywhere?
What type of pain is it (sharp, shooting, dull, achy, tight)?
How bad is the pain (0-10 scale. 0 – no pain, 10 – unbearable)?
What makes it worse?
What makes it better?

PAST HISTORY			**FAMILY HISTORY**			**PROBLEMS/RISKS/MEDICATIONS**
Cancer	Y	N	Cancer	Y	N	
Diabetes	Y	N	Diabetes	Y	N	
Stroke	Y	N	Stroke	Y	N	______________________
Cardio-vascular	Y	N	Cardio-vascular	Y		N



HANOVER
CHIROPRACTIC
& MASSAGE THERAPY

Epilepsy	Y	N	Epilepsy	Y	N	________________________
Surgery	Y	N	Main Complaint	Y		N
Significant falls	Y	N	Arthritis	Y	N	________________________
Auto-accidents	Y	N				
Current Medication	Y		N			________________________