CONFIDENTIAL
HEALTH QUESTIONNAIRE

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: ________________

Current Address (If different than MB Health Card): ____

City: ______________________________ Province: ____________________ Postal Code: ________________

Email Address: ____

Occupation/Profession: ____

Date of Birth: ________________/__________/__________ Sex: M F
(MONTH) (DAY) (YEAR)

MB Health Card:

6 Digit REG #: ____________________

9 Digit PHIN #: ____________________

Name of Medical Doctor: ____

Did another patient of ours, refer you to us? YES NO If yes, who: ______________________________

History of Present Health:

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

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

Previous Treatment:

What Treatment For This Current Condition Have You Had Prescribed:

____

Have you been X-rayed during the last 2 years? YES NO If Yes, Where were they taken? ____________________

History of Past Health/Past Illnesses:

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

Back Pain • Neck Pain • Arm Pain • Leg Pain • Other:____

Significant Health Illnesses:

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

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

Any Significant Accidents or Falls: Please List: ____

Any Operations or Surgery: Please List: ____

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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: ____________________

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