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

NIVERVILLE FAMILY CHIROPRACTIC
102-106 Main St., Niverville, MB R0A 0A1
204.881.5555

PATIENT HISTORY FORM

Today's Date: _____

Name_____ MHSC # _____ Reg# _____
(As it appears on MHSC card)
Date of Birth _____/_____/_____ Current Age_____ Height_____
(day / month / year)
Address _____ City _____ Province _____ Postal Code_____

Phone: Home _____ Work _____ Cell _____

Email Address _____ Occupation _____

Employer _____ Spouse's Name _____

Names and ages of children _____ Are you pregnant? Yes/No (Circle)

Will you be claiming: Autopac (MPI) Yes ☐ No ☐ Worker's Compensation Yes ☐ No ☐

If yes: Injury/Accident Date: _____ Personal Injury Claim # _____

CHIROPRACTIC HISTORY:

Have you been to a chiropractor before? Y ☐ N ☐ Date of last visit: _____
Name of last chiropractor: _____
What are your health goals in our office:
☐ Symptom Relief ☐ Wellness Care ☐ 100% Vitality & Health

HEALTH HISTORY:

Please rate your overall health status:
Poor 1 2 3 4 5 6 7 8 9 10 Excellent
Are you healthier today than you were five years ago? Y ☐ N ☐
If yes, what have you done to improve your health?_____
_____

WHAT IS YOUR MAJOR COMPLAINT FOR WHICH YOU ARE SEEKING CHIROPRACTIC CARE?

_____

_____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start?_____ How?_____
Is it ☐ getting better ☐ getting worse ☐ staying the same?
How would you describe the problem?_____
Are you taking medication for this condition? Y ☐ N ☐
If yes, which medication:_____Dose: ____
Please list ALL other medications you are currently taking:_____
_____
_____

PLEASE ELABORATE ON FURTHER COMPLAINTS ON A SEPARATE PAGE (IF NECESSARY)

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PRESENT HEALTH CONCERNS- IN THE PAST 3 MONTHS, HAVE YOU BEEN AFFECTED BY ANY OF THE FOLLOWING? *Please check: O- Occasional F- Frequent C- Constant*

MUSCLE & JOINT	O	F	C
Backaches	☐	☐	☐
Neck Pain	☐	☐	☐
Painful Tailbone	☐	☐	☐
Foot Trouble	☐	☐	☐
Shoulder Pain	☐	☐	☐
Hernia	☐	☐	☐
Faulty Posture	☐	☐	☐
Arthritis	☐	☐	☐

STRESS SYMPTOMS			
Headaches/Migraines	☐	☐	☐
Dizziness	☐	☐	☐
Numbness in Arms/Hands	☐	☐	☐
Numbness in Legs/Feet	☐	☐	☐
Ringing in Ears	☐	☐	☐
Blurring of Vision	☐	☐	☐
Loss of Sleep	☐	☐	☐
Loss of Memory	☐	☐	☐
Irritable	☐	☐	☐
Depression	☐	☐	☐
Decreased Energy	☐	☐	☐
Tension	☐	☐	☐
Anxiety	☐	☐	☐
Nervous	☐	☐	☐

URINARY			
Painful Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in Urine	☐	☐	☐
Trouble Urinating	☐	☐	☐

RESPIRATORY	O	F	C
Chronic Cough	☐	☐	☐
Spitting Up Phlegm	☐	☐	☐
Spitting Up Blood	☐	☐	☐
Chest Pain	☐	☐	☐
Difficult Breathing	☐	☐	☐
Colds	☐	☐	☐

GASTROINTESTINAL			
Difficult Digestion	☐	☐	☐
Belching or Gas	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Stomach Pain	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Liver Trouble	☐	☐	☐
Gallbladder Pain	☐	☐	☐
Bloody Stool	☐	☐	☐
Heartburn	☐	☐	☐
Change of Appetite	☐	☐	☐

EYES, EARS, NOSE, THROAT			
Earache	☐	☐	☐
Sore Throat	☐	☐	☐
Asthma	☐	☐	☐
Tonsillitis	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sinus Infection	☐	☐	☐
Ear Infections	☐	☐	☐
Trouble Hearing	☐	☐	☐

CARDIOVASCULAR	O	F	C
Rapid Heart Beat	☐	☐	☐
Slow Heart Beat	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Pain Over Heart	☐	☐	☐
Swelling of Ankles	☐	☐	☐
Poor Circulation	☐	☐	☐
Previous Stroke	☐	☐	☐

GENERAL/NERVOUS SYMPTOMS			
Fever/Chills	☐	☐	☐
Fainting	☐	☐	☐
Skin Problems	☐	☐	☐
Convulsions	☐	☐	☐
Tremors	☐	☐	☐
Loss of Balance	☐	☐	☐
Allergy	☐	☐	☐

FEMALES ONLY	Y	N
Painful Menstruation	☐	☐
Irregular Cycle	☐	☐
Cramps & Backache	☐	☐
Excessive Flow	☐	☐
Abnormal Discharge	☐	☐
Menopause	☐	☐
Birth Control Pills	☐	☐

Date of last period: _____

PAST HEALTH- HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

	Y	N		Y	N		Y	N		Y	N
Thyroid Trouble	☐	☐	Emotional problems	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Pneumonia	☐	☐	Alcoholism	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Back pain	☐	☐	Stomach Ulcers	☐	☐	HIV/AIDS	☐	☐
Heart Disease	☐	☐	Headaches	☐	☐	Psoriasis	☐	☐	Asthma	☐	☐
Allergies	☐	☐	Epileptic Seizures	☐	☐	Polio	☐	☐	Tuberculosis	☐	☐
Other	☐	☐									

If so, please elaborate _____

PLEASE LIST ANY SIGNIFICANT ILLNESSES, OPERATIONS, ACCIDENTS, FALLS, OR TRAUMAS

DATE	ILLNESS/OPERATION/ACCIDENTS/FALLS/TRAUMAS

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Family Chiropractic

Manitoba Chiropractors Association

October 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name

_____ _____ _____
Patient/Guardian Date Chiropractor

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