

Please check off accordingly: **C** = Current **P** = Past **For practitioner:** 4+ Current MB or 6+ Past MB, please refer to ND

<p>Injury Date: MMDDYYYY</p> <p>Nature of injury: _____</p> <p>MVA/WSIB/Other _____</p> <p>General History C P</p> <p>Trauma <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever/Chills <input type="checkbox"/> <input type="checkbox"/></p> <p>Allergies^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Malaise/Fatigue^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Weakness^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Medications (List Below) _____</p> <p>_____</p> <p>Surgeries (List Below — INCLUDE ANY DENTAL WORK/AMALGUM FILLINGS) _____</p> <p>_____</p>	<p>Gastrointestinal System C P</p> <p>Peptic Ulcer^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Nausea/Vomiting^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Indigestion/heartburn^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Abdominal Pain^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Abdominal Swelling <input type="checkbox"/> <input type="checkbox"/></p> <p>Constipation^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Diarrhea^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Hemorrhoids^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Hernia <input type="checkbox"/> <input type="checkbox"/></p> <p>Gall Bladder Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Liver Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Pancreatitis <input type="checkbox"/> <input type="checkbox"/></p> <p>Alcohol Intake <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>Respiratory System C P</p> <p>Difficulty Breathing <input type="checkbox"/> <input type="checkbox"/></p> <p>Cough <input type="checkbox"/> <input type="checkbox"/></p> <p>Wheezing/Asthma^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis exposure <input type="checkbox"/> <input type="checkbox"/></p> <p>Pneumonia <input type="checkbox"/> <input type="checkbox"/></p> <p>Lung Infections <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you smoke <input type="checkbox"/> yes <input type="checkbox"/> no _____Packs/day</p> <p>Other _____</p> <p>Cardiovascular System C P</p> <p>Shortness of Breath <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest Discomfort/Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Arm Discomfort/Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Palpitations <input type="checkbox"/> <input type="checkbox"/></p> <p>Edema/Swelling <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting <input type="checkbox"/> <input type="checkbox"/></p> <p>Sudden calf pain when walking <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>High/Low blood pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you have a pacemaker? Yes<input type="checkbox"/>/No<input type="checkbox"/></p> <p>Other _____</p> <p>Skin/Hair/Nails C P</p> <p>Change in Skin Temp. <input type="checkbox"/> <input type="checkbox"/></p> <p>Change in Skin Texture <input type="checkbox"/> <input type="checkbox"/></p> <p>Skin Dryness/Wetness <input type="checkbox"/> <input type="checkbox"/></p> <p>Rashes/Itching/Sores^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Skin Growths <input type="checkbox"/> <input type="checkbox"/></p> <p>Mole Changes <input type="checkbox"/> <input type="checkbox"/></p> <p>Skin Cancer <input type="checkbox"/> <input type="checkbox"/></p> <p>Change in Nail Shape/Colour <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p>	<p>Neurological System C P</p> <p>Headaches/Migraines^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Epileptic Seizures <input type="checkbox"/> <input type="checkbox"/></p> <p>Tics/Spasms <input type="checkbox"/> <input type="checkbox"/></p> <p>Dizziness/Fainting <input type="checkbox"/> <input type="checkbox"/></p> <p>Sensation Disturbances <input type="checkbox"/> <input type="checkbox"/></p> <p>Unusual Weakness <input type="checkbox"/> <input type="checkbox"/></p> <p>Head Trauma <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>Musculoskeletal System C P</p> <p>Joint Stiffness <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Swelling <input type="checkbox"/> <input type="checkbox"/></p> <p>Muscle Cramps <input type="checkbox"/> <input type="checkbox"/></p> <p>Muscle Weakness <input type="checkbox"/> <input type="checkbox"/></p> <p>Muscle Wasting <input type="checkbox"/> <input type="checkbox"/></p> <p>Neck Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Mid Back Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Low Back Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Sacroiliac Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Tailbone Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Arm Problem <input type="checkbox"/> <input type="checkbox"/></p> <p>Leg Problem <input type="checkbox"/> <input type="checkbox"/></p> <p>Fractures/Dislocation <input type="checkbox"/> <input type="checkbox"/></p> <p>Sprains/Strains <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>ANY OTHER DIAGNOSED HEALTH CONDITIONS?</p> <p>Herpes <input type="checkbox"/> <input type="checkbox"/></p> <p>HIV / AIDS <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis (TB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis A/B/C <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you currently receiving treatment from another health care professional?</p> <p>Yes/No; If yes for what _____</p> <p>_____</p> <p>Do you feel that you currently have significant stress in your life?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I am <u>optimistic</u> that my present problem will improve. (Please circle one)</p> <p>1 = strongly disagree</p> <p>2 = disagree</p> <p>3 = no opinion</p> <p>4 = agree</p> <p>5 = strongly agree</p> <p>FEMALE PATIENTS ONLY</p> <p><input type="checkbox"/> Onset of last period</p> <p>Date: _____</p> <p><input type="checkbox"/> Are you pregnant: Yes/No</p> <p>Due Date: _____</p> <p><input type="checkbox"/> Birth control method Indicate^(MB): _____</p> <p>_____</p> <p>Date: _____</p> <p>Patient Signature: _____</p> <p>Provider Signature: _____</p> <p>*****IF NOTHING APPLIES PLEASE SIGN THE ABOVE ACKNOWLEDGING YOU ARE IN GOOD HEALTH.*****</p>
<p>Family History C P</p> <p>Diabetes <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>↑ or ↓ Blood Pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Disease/Stroke <input type="checkbox"/> <input type="checkbox"/></p> <p>Musculoskeletal disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p>	<p>Endocrine System C P</p> <p>Heat/Cold Intolerance <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Problems^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>Eye/Ear/Nose/Throat C P</p> <p>Visual Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Pain in eyes <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Hearing <input type="checkbox"/> <input type="checkbox"/></p> <p>Ringing in Ears <input type="checkbox"/> <input type="checkbox"/></p> <p>Dizziness <input type="checkbox"/> <input type="checkbox"/></p> <p>Ear Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Ear Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p>Change in Smell <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinusitis^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Hoarseness <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Swallowing <input type="checkbox"/> <input type="checkbox"/></p> <p>Change in Taste <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>Genito-Urinary System C P</p> <p>Pain on Urination <input type="checkbox"/> <input type="checkbox"/></p> <p>Change in Urine Colour <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Starting Stream <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Holding Urine <input type="checkbox"/> <input type="checkbox"/></p> <p>Urinary Tract Infection^(MB) <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Flank Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Prostate Problem <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p>	