

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

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