NACHTIGALL
& ASSOCIATES · CHIROPRACTIC

Dr. H. Nachtigall, D.C.
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Patient Intake Form

Please Print Clearly

All information gathered is confidential and will not be released to anyone without your approval. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Manitoba Health #: _____ **PHIN#:** _____
Name: _____ □M □F **Age:** _____ **Birthdate:**_____
Address: _____ **City/Province:** _____ **Postal Code:**_____
Phone #: (home)_____ (cell)_____ (work)_____
Email: _____ **May we contact you via email?** □ Yes □ No
Marital Status: S / M / D / W / Other **Sig.Other's Name:** _____ **# of Children:** _____
Emergency Contact & Phone Number: _____
Occupation: _____
Employer & Address: _____
Common Activities at Work: □ Sitting □ Standing □ Walking □ Bending □ Other _____
How did you hear about our office? □ Phonebook □ Office Sign □ Newspaper Ad □ Social Media
□ Other _____ □ Family/Friend _____ **May we thank them for the referral?**□Yes□ No

Have you had previous chiropractic care? □ Yes □ No Chiropractor: _____
Result of Past Care: □ Excellent □ Good □ Fair □ Poor Last Visit: _____
Who is your Medical Doctor?_____ Date of Last Physical: _____
Please list all medications: _____
Have you had X-rays taken in the last 5 years?□Yes □No Location: _____
Do you Smoke? □ Yes □ No **Consume Alcohol?** □ Yes □ No
Do you take supplements? □ Yes □ No _____
Hours of sleep per night: _____ **Do you wake feeling rested?** □ Yes □ No
Do you exercise? □ Yes □ No If yes, how often? _____ Exercise Type? _____
# of meals per day: □ 1 □ 2 □ 3 □ 4 □ 5+ Dietary Restrictions: _____
Foods eaten regularly: □ Fruits □ Vegetables □ Dairy □ Meat □ Grains □ Other_____
Rate Your Diet: □ Excellent □ Good □ Fair □ Poor
Rate Your Appetite: □ Excellent □ Good □ Fair □ Poor
Have you had a(n): □ Auto Accident □ Work-Related Accident □ Sports-Related Accident
□ In the past year □ In the past 5 years □ In over 5 years

Describe major complaint in detail: _____
_____
_____
How long have you had this condition:_____ **Have you had this in the past?** □Yes □No
The condition is getting: □ Better □ Worse □ Not Changing **It is:** □ Constant □ Coming and Going
The condition interferes with: □Work □Sleep □Daily Activity □Sports □ Other_____
Have you seen any other providers for this condition? □Yes □No _____
What other treatments have you received for this condition?_____
Did you: □ sustain a blow to the head □ sustain scrapes, cuts, or bruises □ sustain loss of consciousness?
Did you see any healthcare within 24 hours? □Yes □No
Have you missed work?□Yes □No Dates Missed:_____ **Are you currently working?** □Yes □No
Are you performing your regular duties? □Yes □No **Are you performing modified duties?** □Yes □No
Which duties do you feel you cannot do? _____
Are you claiming for an accident under: □ MPI □WCB **Date of Accident**: _____
Claim #:_____ **Have you ever had a WCB claim before?** □ Yes □ No

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Current & Past Health History

Please Print Clearly

Using a scale from 0 (no pain) – 10 (worst pain imaginable), how would you rate your complaint?

0 1 2 3 4 5 6 7 8 9 10

Have you ever had any of the following conditions? (Please Circle)

Aneurysm	Osteoporosis	Diabetes	Stroke	Fractures	Sleeping Difficulty
Cancer	High Blood Pressure	Arthritis	Asthma	Pneumonia	T.B.
Polio	Low Blood Pressure	Hepatitis	Epilepsy	Sinus Problem	V.D.
Psoriasis	Heart Condition	Pleurisy	Fatigue	Allergies	
Childhood Conditions:					
Measles	Rheumatic Fever	Chicken Pox	Scarlet Fever	Diphtheria	Typhoid fever
Mumps	Whooping Cough	Ear Infections	Tubes in Ears	Colic	Chronic Illness

Do you have a family history of: □Heart Attack □Stroke □Cancer □Diabetes □Other: _____

List all surgeries and years performed: _____

_____

Please check the symptoms which you are currently experiencing or that have occurred in the past:

Current	Past	General
□	□	Headaches
□	□	Sweats/Fever
□	□	Chills
□	□	Fainting
□	□	Dizziness
□	□	Nervousness
□	□	Weight Loss/Gain
□	□	Weak/Numb Limbs
□	□	Fatigue
□	□	Depression/Anxiety
□	□	Forgetfulness/Confusion
		Muscles & Joints
□	□	Stiff/Sore Neck
□	□	Backache
□	□	Swollen Joints
□	□	Painful Tailbone
□	□	Spinal Curvature
□	□	Faulty Posture
□	□	Foot Problems
□	□	Tremors
		Genitourinary
□	□	Infections
□	□	Urination Problems
□	□	Blood or Pus in Urine
□	□	Bed Wetting
□	□	Prostate Problems
□	□	Kidney Stones

Current	Past	Digestive System
□	□	Blood in Stool
□	□	Gas/Belching
□	□	Nausea/Vomiting
□	□	Pain/Cramps
□	□	Constipation
□	□	Diarrhea
□	□	Hemorrhoids
□	□	Colitis
□	□	Bloating
□	□	Indigestion
□	□	Hernia
□	□	Liver Cirrhosis
□	□	Gall Stones
		Respiratory
□	□	Cough
□	□	Difficult Breathing
□	□	Asthma
□	□	Shortness of Breath
□	□	Coughing Phlegm
□	□	Coughing Blood
□	□	Wheezing
		Heart
□	□	Pain in Chest
□	□	Swelling of Ankles
□	□	Poor Circulation
□	□	Hardening of Arteries
□	□	Rapid Heartbeat

Current	Past	EENT
□	□	Vision Problems
□	□	Hearing Problems
□	□	Nose Problems
□	□	Throat Problems
□	□	Mouth Problems
□	□	Nose Bleeds
□	□	Frequent Colds
□	□	Enlarged Glands
		Women
□	□	Lack of Concentration
□	□	Painful Menstruation
□	□	Excessive Flow
□	□	Irregular Cycle
□	□	Menopausal Symptoms
□	□	Hot Flashes
□	□	Previous Miscarriage
□	□	Discharge
□	□	Lumps in Breast
□	□	Loss of Normal Sex

Other:_____
_____
_____
_____
_____
_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Nachtigall & Associates Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Nachtigall & Associates Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due, and I will be assessed an interest charge of 1.5% per month on any outstanding balance.

Signature (patient or guardian): _____ Date: _____