Optimal Care Wellness Center

INFORMATION ABOUT YOU Date________________________

First Name:__________________Middle Name:_____________ Last Name:_________________

Birthday (dd/mm/yyyy) ____/____/______ Current Age:_______

Address:____

City:____________________ Province:_______________ Postal Code:___________

Home #:__________________ Work:_________________ Cell:______________________

Email Address:____

Occupation:_________________________ Employer:___________________________

Are you Pregnant: (circle) Yes / No

Who can we thank for referring you to our office?_______________________________________

INSURANCE INFORMATION

Company: ________________ Certificate #: ________________ ID/Firm #: ________________

MANITOBA HEALTH REGISTRATION #:(6 Digit)____________(9 Digit)__________________

IS THE INJURY CAUSED BY A MOTOR VEHICLE ACCIDENT? YES / NO

Accident Date:_______________ **Personal Injury Claim #:**________________

DID YOUR INJURY OCCUR WHILE AT WORK? YES / NO

Injury Date:_______________ **Personal Injury Claim #:**________________

CHIROPRACTIC HISTORY:

Have you been to a chiropractor before? Y / N Date of Last Visit:_________________________

Name of Last Chiropractor: ____

MAJOR HEALTH CONCERNS – PLEASE FILL IN ALL AREAS: IF NOT APPLICABLE PLEASE PUT "N/A"

What condition brought you to our office?:____

On a scale of 1-10 (10 being severe) How bad is the problem?:_____________________________

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 list all surgeries you have had: