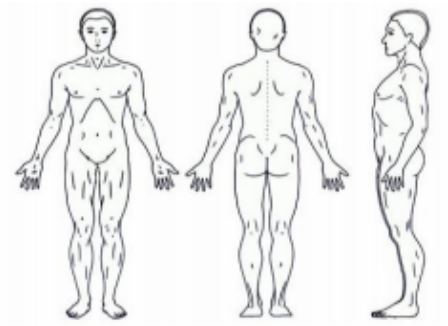
NACHTIGALL
& ASSOCIATES • CHIROPRACTIC INC.

CHIROPRACTIC • MASSAGE THERAPY
ATHLETIC THERAPY • ACUPUNCTURE

New Patient Intake Form

Dr. H. Nachtigall, D.C.
Dr. C. Capiendo, BSc, D.C.
Erika Andrejowich, BSc, C.A.T. (C)
Christine Gilbank, RMT

How did you hear about us? (Please circle one)				
Family/Friend: May we thank them? Yes No	In the area/sign Social Media: FB Instagram Google Other:			
Patient Information				
Manitoba Health #	PHIN#	M F	DOB:	Age:
Name:	Cell:		Home:	
Address:	City/Prov.		Postal Code:	
Email:	Occupation			
Work Phone:	Employer:			
Marital Status: S M D W Other Sig. Other's Name:			# of Children:	
Emergency Contact				
Name:	Relationship:		Phone Number:	
Health Care Providers				
Have you had previous chiropractic care? Yes No	Chiropractor:			
When was your last visit? How many visits have you had this year?	Results of past care: Good Fair Poor			
Medical/Family Doctor:	Date of Last Physical:			
List of all Medication:				
Have you had X-rays, CTs or MRIs in the last 5 years? Yes No Area of the body: Location of Imaging:				
Lifestyle History				
Do you Smoke? Yes No	Do you consume alcohol? Yes No			
List of all supplements:				
Hours of sleep per night:	Do you wake feeling rested? Yes No			
Have you experienced any unexpected weight loss or gain?				
Pain/Injury History				
Please put an X on the body diagram where you are experiencing pain/symptoms: 	Pain Scale (0 none; 10 extreme) **0 1 2 3 4 5 6 7 8 9 10** 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			
	The pain is: □Constant □Coming and Going □Better □Worse			
	The condition interferes with: Work/Sleep/Daily Activities/Sports/Other:			
	Have you seen any other providers for this condition? Yes No Who:			
Are you claiming WCB or MPI (circle one)	If Yes - Claim #		Date of injury:	
Have you missed work? Yes No How many days:	Are you performing REGULAR or MODIFIED duties (circle one)			
Which duties do you feel you cannot do:				

Current & Past Health History

Have you ever had any of the following conditions? (Please Circle)					
Aneurysm	Osteoporosis	Diabetes	Stroke	Fractures	Sleeping Difficulty
Cancer	T.B	Arthritis	Asthma	Pneumonia	High Blood Pressure
Polio	V.D	Hepatitis	Epilepsy	Sinus Issues	Low Blood Pressure
Psoriasis	Heart Condition	Pleurisy	Fatigue	Allergies	
Childhood conditions					
Measles	Rheumatic Fever	Chicken Pox	Scarlet Fever	Diphtheria	Typhoid Fever
Mumps	Whooping Cough	Ear Infection	Tubes in Ears	Colic	

Do you have a family history of: □Heart Attack □ Stroke □ Cancer □ Diabetes □ Other:_____
List all surgeries and years performed: _____
_____
_____

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

Current	Past	**General**
□	□	Headaches
□	□	Sweats/Fevers
□	□	Chills
□	□	Fainting
□	□	Dizziness
□	□	Nervousness
□	□	Weight gain/loss
□	□	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
□	□	Constipations
□	□	Diarrhea
□	□	Hemorrhoids
□	□	Colitis
□	□	Bloating
□	□	Indigestion
□	□	Hernia
□	□	Liver Cirrhosis
□	□	Gall Stones
		Respiratory
□	□	Cough
□	□	Difficult Breathing
□	□	Asthmas
□	□	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 Inc. 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 Inc. 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 charge for professional services to me will be immediately due, and I will be assessed at an interest charge of 1.5% per month on any outstanding balance.

Signature (patient or guardian):_____ Date:_____