NACHTIGALL
& ASSOCIATES • CHIROPRACTIC INC.

CHIROPRACTIC • MASSAGE THERAPY
ATHLETIC THERAPY • ACUPUNCTURE

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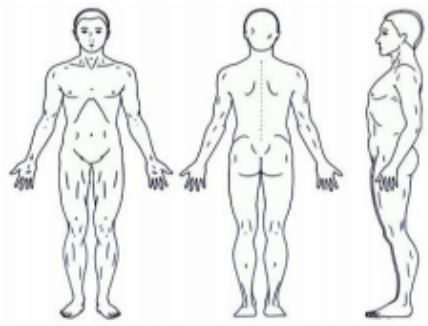
OUCH (re/new injury) Form

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:

Incident History	
Have you seen other providers for this injury? Yes No	Who:
When was your last visit:	Results of past care: Good Fair Poor
Medical/Family Doctor:	Date of Last appointment:
List of all Medication:	Have you had X-rays, CTs or MRIs for this incident? Yes No
	Location of imaging:
Did you go to the hospital for this incident? Yes No	Did you lose consciousness? Yes No

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** **Please describe your complaint in detail**	
	Is this □ MPI □WCB	Claim number:
	Date of incident:	Did you notify work? Yes No Who:
	Have you missed work? Yes No	How many days:
	How long have you had this condition?	
	Have you had this in the past? Yes No When:	
	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:	
	Are you performing REGULAR or MODIFIED duties (circle one)	
Which duties do you feel you cannot do:		