FOCUS
CHIROPRACTIC CENTRE

NEW PATIENT CASE HISTORY: MANITOBA PUBLIC INSURANCE

Name: ______________________________ Date: ______________

Address: ______________________________ City, Postal Code: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Gender: M F Birth Date (MM/DD/YY) ___ / ____ / ___

MPI Claim #: ______________________________

Adjuster:______________________________ Date of accident: ______________

Have you missed work because of the accident? Yes No If so, how many days? ______________

Are you still missing work? Yes No If so, when do you anticipate returning? ______________

Please describe the accident in detail: ______________________________

____

Did you go to the hospital? Yes No If so, what was the duration of stay? ______________

Was an ambulance called? Yes No Treatment received: ______________

Was there a police report? Yes No Did any part of your body hit the inside of the car? Which part? ______________

Describe all injuries sustained: ______________________________

Main Complaint: ______________________________

Rate your pain on a scale of **1 to 10** with **zero** being no pain and **10** being the worst pain

0 1 2 3 4 5 6 7 8 9 10

Was YOUR car stopped at the time? Yes No If no, what was your estimated speed? ______________

What was the damage to your vehicle? ______________ Estimated cost of repairs: ______________

Was the OTHER car stopped at the time? Yes No If no, what was their estimated speed? ______________

What was the damage to the other vehicle? ______________

Did you see the other car before the collision? Yes No

Wearing seatbelt? Yes No Was your head turned? Yes No Was your body turned? Yes No

Where were you seated? Driving Passenger Left back seat Right back seat

Have you seen any other practitioners since your accident? Type: ______________ Who? ______________

Treatment received: ______________________________ Still attending? Yes No

SYMPTOMS YOU MAY HAVE NOTICED SINCE YOUR ACCIDENT: *(please circle ALL that apply)*

Head Injuries

Headaches	Visual Problems	Ear Noises	Memory Loss	Loss of Balance
Light Sensitivities	Light Headed	Dizziness	Face Pain	Tension
Hearing Loss	Jaw Pain	Fainting	Pain in Ears	Head Heaviness

Neck Injuries

Stiff Neck	Hard to Move Neck	Grinding Sound	Sore Neck	Neck Spasm
Hard to Swallow				

Shoulder, Arm, and Chest Injuries

Between Shoulders	Numbness	Cold Hands	Can't Raise Arm	Pain
Rib Pain	Shoulder Spasm	Tingling	Shortness of Breath	

Low Back Injuries

Low Back Pain	Difficulty Standing	Painful Coughing	Tailbone Pain	Difficulty Sitting

Leg Injuries

Leg Numbness	Buttock Pain	Knee, Calf Pain	Swollen Ankles	Leg Tingling
Ankle, Foot, Toe Pain	Hip Pain	Leg Pain	Cold Feet	Difficulty Walking

Specific Symptoms

Confusion	Nausea	Diarrhea	Disorientation	Abdominal Pain
Anxiety	Irritability	Gas	Depression	Nervous Stomach
Constipation	Insomnia	Weight Loss	Bruises	Heart Palpitation
Urinary Problems	Lacerations	Tremors	Restlessness	Broken Bones
Sexual Dysfunction	Blackouts	Difficulty Breathing	Afraid of Cars	Loss of Appetite
Less Alert	Afraid of Driving			

Do you have a family history of: Diabetes Stroke Cancer

Do you or have you smoked? Yes No, if yes how often: ______________________________

Do you exercise? Yes No, if yes how often: ______________________________

Have you had any previous: Fractures Surgeries Vehicle Accidents Hospitalizations

Do you take any medications? Yes No, if yes please list: ______________________________

The above information is true and accurate to the best of my knowledge.

______________________________ ______________

Signature Date