



Roblin Family Chiropractic Centre

3525 Roblin Blvd • Unit C • Winnipeg • Manitoba • R3R 0S6 • (204) 885-6640
Dr. Michael G. Plueschow

HEALTH HISTORY

Date _____ Chart No _____

Name _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone (204) _____ Work Phone (204) _____ Birth Date (D/M/Y) _____

MHSC: 6 Digit _____ 9 Digit _____ Age _____

Occupation _____ Spouse (Name) _____

Children (Name/Age) _____

E-Mail Address _____

Who referred you to us? _____

Past Chiropractic Care? [Yes] [No] Date of Last Visit? _____

Do you have reason to believe you may be pregnant? [Yes] [No] Due Date _____

Is this a Work Injury? [Yes] [No] Claim # _____

Is this Auto Accident Injury? [Yes] [No] Claim # _____

Briefly describe your complaint _____

THERE ARE FIVE WAYS OUR PATIENTS USE CHIROPRACTIC CARE:

- **RELIEF CARE** to relieve the most obvious symptoms
- **CORRECTIVE CARE** to correct underlying problems and the return of symptoms
- **MAINTENANCE CARE** to sustain progress
- **PREVENTIVE CARE** to catch new problems early
- **WELLNESS CARE** to be your best and to stay that way

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X"

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> FAINTING | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> LOW BACK PAIN |
| <input type="checkbox"/> SHOOTING HEAD PAINS | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> KIDNEY TROUBLE |
| <input type="checkbox"/> LOSS OF SMELL | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> MENSTRUAL CRAMPS & PAINS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> LIGHTS BOTHER EYES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> LOSS OF TASTE | <input type="checkbox"/> MUSCLE SPASMS IN NECK | <input type="checkbox"/> NERVOUS STOMACH | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> TIGHTNESS OF THROAT | <input type="checkbox"/> GRATING IN NECK | <input type="checkbox"/> STOMACH TROUBLE | <input type="checkbox"/> SLEEPING PROBLEMS |
| <input type="checkbox"/> INFLAMMATION OF THROAT | <input type="checkbox"/> TIGHTNESS IN SHOULDER MUSCLES | <input type="checkbox"/> ULCERS | <input type="checkbox"/> PAINFUL JOINTS |
| <input type="checkbox"/> FACE FLUSHED | <input type="checkbox"/> RADIATING PAIN IN SHOULDERS & ARMS | <input type="checkbox"/> NERVES & NERVOUSNESS | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> TWITCHING OF FACE | <input type="checkbox"/> PINS & NEEDLES IN ARMS& HANDS | <input type="checkbox"/> INNER TENSION | <input type="checkbox"/> PINCHED NERVES IN BACK |
| <input type="checkbox"/> LOSS OF MEMORY | <input type="checkbox"/> COLD HANDS | <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> PINS & NEEDLES IN LEGS |
| <input type="checkbox"/> FATIGUE | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> SWOLLEN ANKLES |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> LIVER TROUBLE | <input type="checkbox"/> COLD FEET |
| <input type="checkbox"/> HEAD FEELS TOO HEAVY | <input type="checkbox"/> HEART PAIN | <input type="checkbox"/> GALL BLADDER TROUBLE | <input type="checkbox"/> PAINS IN LEGS & FEET |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> HEART PALPITATIONS | <input type="checkbox"/> INDIGESTION | |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> MID-BACK PAIN | | |

Prescription Drug use?

Initial Examination	\$35.00 (Adults) & \$25.00 (Child/Senior)
X-Rays	\$80.00 (\$20.00 per View)
Adjustment	\$34.00 (Adults) & \$25.00 (Child/Senior)
Adjustment + Manitoba Health	\$23.00 (Adults) & \$15.00 (Child/Senior)
(12 visits per year)	

WE ACCEPT PAYMENT BY CASH, CHECK, DEBIT, AND CREDIT CARD

All services are to be paid in full at the time of service

Signature _____ **Date** _____

With this signature I give consent to have a spinal/extremity examination and a radiological examination, (if deemed necessary) for the purposes of locating spinal/extremity anomalies.

Our Mission

We are dedicated to enhancing the Health Potential and Wellness of humanity through the Principles and Philosophy of Chiropractic.

We do this to help everyone achieve personal wellness, excellence and self fulfillment.