East Lothian Chiropractic - The Keystone to Health & Wellbeing

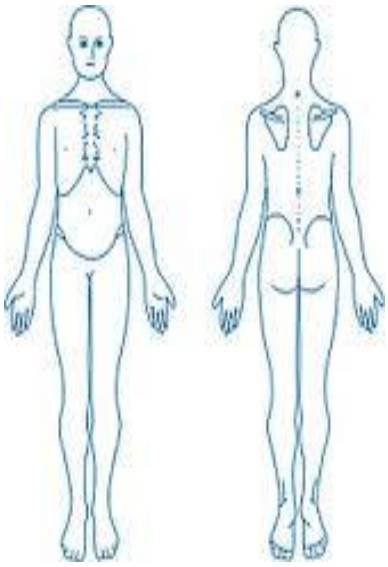
Name: **Date of Birth:**

PRESENTING COMPLAINT

- Please list your complaints/symptoms in order of severity.

1._____ For how long?_____

2._____ For how long?_____



- Please mark area of complaint/symptoms on the diagram

- Please describe the pain:

☐ Sharp ☐ Dull/ache ☐ Shooting

☐ Burning ☐ Throbbing ☐ Numb/tingling

☐ Getting worse ☐ Improving ☐ Constant

- What aggravates the complaint/symptoms?

_____

- What relieves the complaint/symptoms?

_____

- How are these symptoms affecting your life? (Activities of daily living?)

_____

- Have you ever experienced these symptoms before? (please explain)

_____

- What do you think is wrong?

_____

- Does it affect your sleep? **Y / N**

_____

- How long has it been since you felt really well?

_____

- Have you been to see another doctor or health specialist for these symptoms?

_____

HEALTH HISTORY

Please tick box if you have experienced or are experiencing any of the following:

☐ Allergy	☐ Convulsions	☐ Dizziness	☐ Fatigue	☐ Numbness
☐ Loss of Sleep	☐ Loss of weight	☐ Joint Stiffness	☐ Cancer	☐ Fracture
☐ Headaches	☐ Hyperactivity	☐ Haemorrhoids	☐ Diabetes	☐ Epilepsy
☐ Pain Urination	☐ Short of breath	☐ Stroke/TIA's	☐ Vision Problems	☐ Vertigo
☐ Anxiety	☐ Depression	☐ Thyroid	☐ Hernia	☐ Migraines
☐ Low Back Pain	☐ Neck Pain	☐ Pins & Needles	☐ Swollen joints	☐ Inco-ordination
☐ Weakness	☐ Tremors	☐ Poor posture	☐ Gout	☐ Paralysis
☐ Arthritis	☐ Constipation	☐ Diarrhoea	☐ Digestive Prob.	☐ Gallbladder
☐ Liver Problems	☐ Ulcers	☐ Deafness	☐ Ear Infections	☐ Ringing ears
☐ Frequent colds	☐ Poor Circulation	☐ High BP	☐ Low BP	☐ Ankle Swelling
☐ Varicose veins	☐ Chest Pain	☐ Palpitations	☐ Cough	☐ Wheezing
☐ Prostate	☐ Irregular breathing	☐ Blood in urine	☐ Venereal disease	☐ Incontinence

Women only:

☐ Irregular Cycle	☐ Hot Flushes	☐ Excessive Menstruation	☐Menstrual Cramps

FAMILY HISTORY

Is there a family history of any

of the following:

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ High/Low Blood Pressure

MEDICATION

Please list all medication/drugs:

_____

_____

_____

_____

_____

_____

PREVIOUS INJURY

1. Have you been involved in any motor vehicle accidents? Even as a passenger or even if you think you were not hurt? **Y / N**

   If yes, please give details (date/injuries/degree of RTA).

_____

_____

_____

2. Have you had any surgery or been hospitalised? (please give approximate date and details)

_____
_____
_____

3. Have you broken any bones, experienced any sprains or dislocations? (please give dates and details)

_____
_____
_____

YOUR HEALTH PROFILE

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and affect our health. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime and may be presently experiencing, allowing us to better assess and understand the challenges your body has undergone.

CHILDHOOD YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please tick accordingly.

☐ Did you have any childhood illnesses?

☐ Did you have any serious falls as a child?

☐ Did you play sports as a child?

☐ Did you take/use any drugs?

☐ Did you have any surgery?

☐ Have you fallen/jumped from a height over 3 feet?

☐ Were you involved in any car accidents as a child?

☐ As a child, were you under regular Chiropractic care?

ADULT YEARS

☐ Do/did you smoke?

☐ Do/did you drink alcohol?

☐ Do/did you play any adult sports? Y/N

☐ Do/did you participate in extreme sports?

On a scale of 1-10 describe your stress level: (1= none / 10 = extreme)

Occupational _____ Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____

Sleep_____ General Health _____

HEALTH GOALS

It is important for your Chiropractor to know what your health objectives are, what your expectations are and what is important to YOU. Please tick your desired health goals and areas you are most interested in improving:

☐ To be pain free ☐ More energy ☐ Better concentration
☐Deeper relaxation ☐ More balanced posture ☐ More emotional balance
☐ Reduced medication ☐ More disease resistance ☐ Better sleep quality
☐ Improved strength & endurance ☐ Better sports performance, reaction times/reflexes
☐Other _____

(Please circle your answer for the following)

- How long have you been thinking about pursuing your health goals?
  Years Months Weeks
- Are you happy with the way you look and feel?
  YES NO
- How long has it been since you have felt your best?
  Years Months Weeks
- How long do you think it will take to achieve your health goals?
  Years Months Weeks
- Do you understand how Chiropractic can help improve your overall health and wellbeing?
  YES NO
- Would you like to know more about (please tick)

  ☐ Proper nutrition and meal planning ☐Proper exercise routines and techniques
  ☐ How to deal with lifestyle stress

Thank you for taking the time to fill in these forms.

Declaration: The above information is to the best of my knowledge true and correct. I consent to appropriate examination.

Signed: _____ Date:_____

If under 16, I consent for _____ to receive a Chiropractic examination

Signature of parent/guardian _____ Date:_____