

Name:

Date of Birth:

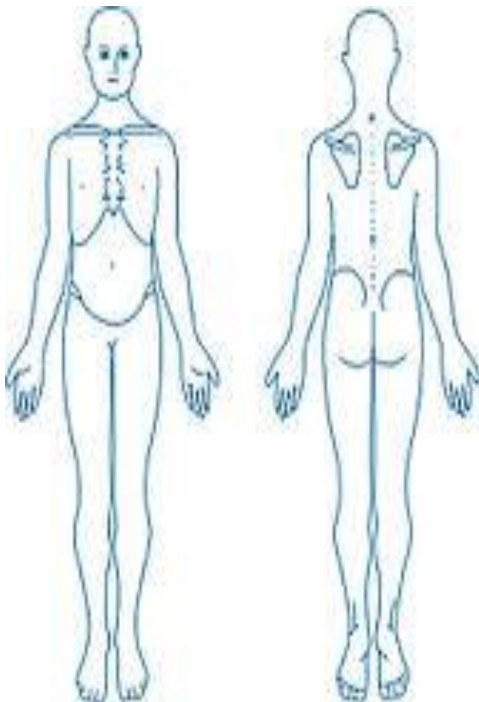
PRESENTING COMPLAINT

- 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:



Is the pain:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull/ache | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numb/tingling |
| <input type="checkbox"/> Getting worse | <input type="checkbox"/> Improving | <input type="checkbox"/> Constant |

What aggravates the complaint/symptoms:

What relieves the complaint/symptoms?

How are the symptoms affecting your daily activities and 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 – who?

HEALTH HISTORY

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

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

Women only:

- Irregular cycle Hot Flushes Excessive Menstruation Menstrual Cramps

FAMILY HISTORY

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.

- | | |
|---|--|
| <input type="checkbox"/> Did you have any childhood illnesses? | <input type="checkbox"/> Did you have any serious falls as a child? |
| <input type="checkbox"/> Did you play sports as a child? | <input type="checkbox"/> Did you take/use any drugs? |
| <input type="checkbox"/> Did you have any surgery? | <input type="checkbox"/> Have you fallen/jumped from a height over 3 feet? |
| <input type="checkbox"/> Were you involved in any car accidents as a child? | <input type="checkbox"/> As a child, were you under regular Chiropractic care? |

ADULT YEARS

- | | |
|--|--|
| <input type="checkbox"/> Do/did you smoke? | <input type="checkbox"/> Do/did you drink alcohol? |
| <input type="checkbox"/> Do/did you play any adult sports? Y/N | <input type="checkbox"/> 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> To be pain free | <input type="checkbox"/> More energy | <input type="checkbox"/> Better concentration |
| <input type="checkbox"/> Deeper relaxation | <input type="checkbox"/> More balanced posture | <input type="checkbox"/> More emotional balance |
| <input type="checkbox"/> Reduced medication | <input type="checkbox"/> More disease resistance | <input type="checkbox"/> Better sleep quality |
| <input type="checkbox"/> Improved strength & endurance | <input type="checkbox"/> Better sports performance, reaction times/reflexes | |
| <input type="checkbox"/> Other _____ | | |

(Please circle your answer for the following)

- How long have you been thinking about pursuing your health goals? **WEEKS MONTHS YEARS**
- Are you happy with how you look and feel? **YES NO**
- How long has it been since you felt your best? **WEEKS MONTHS YEARS**
- How long do you think it will take to achieve your health goals? **WEEKS MONTHS YEARS**
- Do you understand how chiropractic can help improve your overall health and wellbeing? **YES NO**

Would you like to know more about (please tick):

- How to deal with lifestyle stress Nutrition/ Gut Health

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: _____