



FAMILY CHIROPRACTIC

BE FULLY ALIVE

Welcome and thank you for choosing our practice. Please take the time to fill out this form to the best of your knowledge. Chiropractic concerns itself with the function of your whole body and as such your chiropractor needs to know about everything that affects your health, now and in the past. Many of the questions on this form may seem unnecessary but they will help to develop a clearer picture of your whole health, which will enable us to give you the best possible care.

If you are uncomfortable answering any question please leave it blank and move on.

Please be assured that all information given will be treated in the strictest confidence.

Personal Details

Form with fields for Title, Full Name, D.O.B., Address, Post code, Phone N°, Mobile N°, e-mail, Relatives also treated, Daytime activities/ occupation, Other Interests / activities

Family members

Table with 4 columns: Name, Relationship, Age, Any health issues?

Who may we thank for referring you?

Please provide details of your G.P

Name: Practice

Recent/current medication or supplements

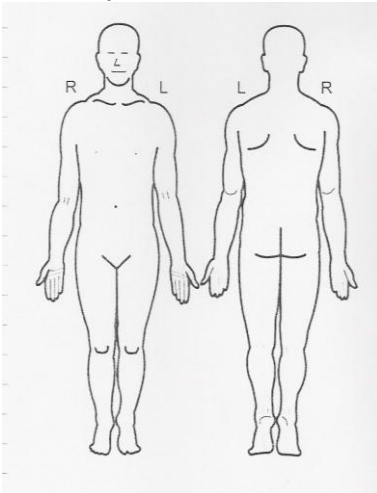
Table with 6 columns: Name, Strength, Started, Stopped, For what, Prescribed by

**Are you suffering any pain or illness conditions at the moment?**

Yes

No

If **Yes** please describe them and mark areas on the diagrams.



\_\_\_\_\_

Severity (1-10):\_\_\_\_\_ % of time:\_\_\_\_\_

How long?\_\_\_\_\_ Date of Onset\_\_\_\_\_

Lost workdays? YES / NO How many?\_\_\_\_\_

When do you notice it most? AM / PM

What makes it better?\_\_\_\_\_ Worse?\_\_\_\_\_

Type of pain~ Aching – Burning – Cramping – Dull – Throbbing – Numbness –

Tingling – Stabbing – Toothachey ~ etc:\_\_\_\_\_

Accident related? NO / Car / Work/Other Date:\_\_\_\_\_

Similar condition before? YES / NO When?\_\_\_\_\_

Do you have any **Pain** and/or **Difficulty** performing any of the following activities: (please circle all that apply)

Personal care – Lifting – Reading – Work – Driving – Walking – Sitting – Standing – Social life – Recreation

**Is this affecting the quality of your life?** Yes No If Yes please give details

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had any investigations?** Yes No If Yes please give details

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Treatment? YES NO** Date of last visit\_\_\_\_\_ Reason for visit\_\_\_\_\_

Please give details

\_\_\_\_\_  
\_\_\_\_\_

Why did you stop this treatment?

**Your Birth**

The birthing process can be quite traumatic on mother and baby. It is often here that subluxations first occur

Were you born:  Premature  On Time  Late  Unsure

At Home  In Hospital  Other  Unsure

Was your birth  Unassisted  Midwife/obstetrician  Forceps/suction  Caesarean  Unsure



**What are your health goals?**

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**How do you aim to achieve these goals?**

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**What would improve your quality of life?**

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**Your diet**

Your diet has a major effect on your health, Do you?

	No	Yes	How much/ how often?
Smoke:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drink alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drink water:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drink tea, coffee	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eat fresh vegetables	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eat fresh fruit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eat sugary foods eg chocolate, sweets, chewing gum. breakfast cereals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drink sugary drinks eg. pop, cola, cordial etc.?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eat processed foods (tinned/ready cooked)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Exercise/activity**

How much time per day/week are you involved in vigorous activity?

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How many hours /day do you watch television?

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How many hours /day on computer/computer games?

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How many hours/day driving?

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**Consent:**

Please delete areas in brackets if not appropriate	Signature
The information I have given is, to the best of my knowledge, true and complete. I understand the purpose of chiropractic care and consent to (my child) being examined.	
I have had the results of the examination explained to me. I have had my questions answered satisfactorily and I consent to chiropractic care. (for my child)	
I consent to my doctor being contacted and consulted as appropriate and a letter being written concerning the care I have received/(my child has received)	

**Date**

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**If signing for a child**

**Please print name  
Relationship to child**

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**Thank you for taking the time to fill in this form**