

WELCOME



Chiropractic
First

Patient Information

Name _____ Date of Birth _____
Address _____ Post code _____
Home phone (_____) _____ Work phone (_____) _____ Mobile _____
Occupation _____ Email _____
Status (please tick): Single Married Divorced Widowed Number of children _____ Ages _____
Private Insurance Co. _____ Will you be claiming insurance? (please tick) Yes No
Reason for consultation: _____

Whom may we thank for referring you to our clinic? _____

Your Health Profile

Why This Form Is Important

As a wellness based chiropractic clinic, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to us, and second, to offer you the opportunity of improved health potential in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the affects 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, allowing us to better assess the challenges to your health potential.

The Early Years (to age 16)

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 answer the following questions to the best of your ability.

Your Childhood Years

Yes No Unsure

Did you have any serious falls or physical traumas as a child?
Did you play youth sports?
Did you have any surgery?
Any prolonged use of medicines such as antibiotics or an inhaler?
As a child were you under regular Chiropractic care?

Comments: _____

Adult (18 to present)

Yes No Unsure

Do/did you smoke?
Do/did you drink alcohol?
Have you been in any accidents?
Have you had any surgery?
Do/did you take any medications/drugs?
Do/did you play any adult sports?

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

Occupational _____ Personal _____

On a scale of Poor, Good or Excellent, please rate your:

Diet: _____ Exercise: _____ Sleep: _____ General health: _____

On a scale of 0-10 (10 being Excellent), rate your quality of life: _____

Addressing the issues that brought you to this office

If you have no symptoms or complaints and are here for Wellness Services, please tick here and then please skip to 'Health Profile'. Otherwise, briefly describe the chief area of complaint.

Chief complaint and cause _____

If you are experiencing pain, is it: Sharp Dull Intermittent (comes & goes) Constant

How long have you been experiencing this problem? _____

Since the problem has started, is it: About the same Getting better Getting worse

What makes it worse? _____

Indicate what your present condition is affecting: Work Sleep Walking Sitting Hobbies Leisure

Rate your level of pain (please circle): No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Other Doctors seen for this problem (please list):

Chiropractor: _____

Medical Doctor: _____

Other: _____

Health Profile

Please tick all symptoms you have ever had, even if they do not seem related to you current problem.

- | | | | |
|-----------------|---------------------|--------------------|----------------------|
| Headaches | Morning stiffness | Breathing problems | Sleep problems |
| Migraines | Fatigue | Blurred vision | Depression |
| Neck Pain | Dizziness | Indigestion | Panic Attacks |
| Mid back pain | Fainting | Constipation | Other: _____ |
| Low back pain | Ringing in ears | Kidney problem | |
| Shoulder pain | Heart trouble | Bladder problems | |
| Arm/wrist pain | High blood pressure | Prostate trouble | Women Only |
| Hip pain | Poor circulation | Diabetes | Hot Flashes / |
| Leg pain | Palpitations | Allergies | Night sweats |
| Knee/Ankle pain | Chest pain | Hot sweats | Heavy menstruation |
| Pins & Needles | Liver problems | Cancer | Painful menstruation |
| Arthritis | Asthma | | Irregular cycle |

For Women Only (we require the following information)

Date of your last period:

Is there any possibility of you being pregnant? (please tick) Yes No

Family Health Profile

At our clinic we are not only interested in your health and well being, but also the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Brothers: _____

Spouse: _____

Sisters: _____

Parents: _____

Others: _____

The statements made on this form are accurate to the best of my recollection. I allow this office to examine me for further evaluation. I also agree that any x-rays taken by this clinic are an important part of the patient's permanent records and as such remain the property of the clinic.

Signed: _____

Date: _____