Patient Case History

All information contained in this questionnaire is strictly confidential.

Full Name: **Date of Birth:**

Address:

Postal Address:

Phone: (H) (W) (M)

Email Address for Newsletters and other events:

Occupation:

Next of Kin Name: **Contact Number:**

Are you a member of a health fund that pays for Chiropractic Care? **Please ✓** ☐ Yes ☐ No ☐ Don't Know

If Yes, please provide name of health fund:

Who may we thank for referring you to our Practice? ☐ Yellow Pages ☐ Signage ☐ Word of mouth – Person's Name:

Your Health Profile

***Why this form is important*.**

As a full spectrum Chiropractic Office, we focus on your ability to be healthy. Throughout life, events/stresses occur (physical, chemical and emotional) which damages your health expression. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, especially to your nervous system, allowing us to better access the challenges to your health potential.

If you have ever had Chiropractic Care, please complete the following:

Name of Chiropractor: Located where?

Why did you seek Chiropractic Care? Date of last Adjustment:

What were the results of your Care? ☐ Excellent ☐ Satisfactory ☐ Fair ☐ Did not help ☐ Worsened

Did the Chiropractor take X-Rays? ☐ Yes ☐ No Did you have a thorough examination? ☐ Yes ☐ No

Addressing the issues that brought you to this office.

***Please describe* the chief area/s of your complaint:**

If you are experiencing Discomfort, is it? ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Constant

Since the problem started, is it? ☐ About the same ☐ Getting better ☐ Getting worse

It interferes with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Other

If, other please describe:

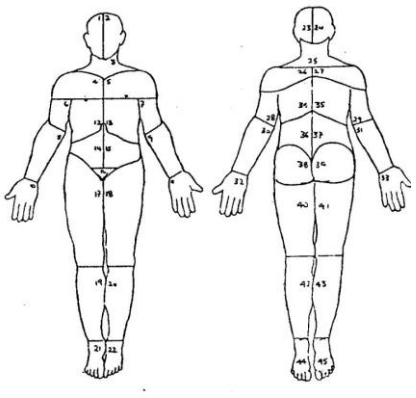
Please ✓ all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Back Discomfort	☐ Constipation/Diarrhea	☐ Headaches	☐ Nausea/Vomiting	☐ Persistent cough
☐ Blurred vision	☐ Depression	☐ Indigestion	☐ Neck stiffness	☐ Pins and needles in arms
☐ Bowel or bladder problems	☐ Dizziness/Fainting	☐ Loss of balance	☐ Numbness in fingers	☐ Pins and needles in legs
☐ Chest Discomfort	☐ Fatigue	☐ Menstrual irregularity Discomfort	☐ Numbness in toes	

Currently your symptoms are aggravated by:

☐ Bending	☐ Reaching	☐ Straining at stool
☐ Coughing	☐ Sitting	☐ Walking
☐ Lifting	☐ Sneezing	☐ Other
☐ Neck movement	☐ Standing	

Please circle affected areas



Front Back

The Beginning Years (to age 17)

Did you have a difficult birth process? ☐ Yes ☐ No ☐ Unsure

Did you participate in aggressive youth sports? ☐ Yes ☐ No ☐ Unsure

Did you have any childhood illnesses? ☐ Yes ☐ No ☐ Unsure

Was there any prolonged use of medication such as antibiotics or an inhaler? ☐ Yes ☐ No ☐ Unsure

As a child, were you under regular Chiropractic Care? ☐ Yes ☐ No ☐ Unsure

Did you have any serious falls/injuries as a child? ☐ Yes ☐ No ☐ Unsure | If Yes, What and When:

Did you have any surgery? ☐ Yes ☐ No ☐ Unsure | If Yes, What and When:

Adult (18 years to present)

Have you had any serious health problems? ☐ Yes ☐ No ☐ unsure

Have you been in any motor vehicle, motor bike accidents or major falls? ☐ Yes ☐ No ☐ unsure If Yes, What and When:

Have you had any surgery or been in hospital? ☐ Yes ☐ No ☐ Unsure If Yes, What and When:

Have you fractured or broken any bones? ☐ Yes ☐ No ☐ Unsure If Yes, What and When:

On a scale of 1 – 10, describe your stress levels (1 = zero 10 = Extreme) Occupational: Personal:

On a scale of Poor Good Excellent describe your: Diet:_____ Exercise:_____ Sleep:_____ General Health:

	Never	Occasionally	Moderately	Excessive
Alcohol	☐	☐	☐	☐
Smoking	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Sodas	☐	☐	☐	☐

Are you currently taking any of the following?

☐ Anti-inflammatory ☐ Muscles relaxants ☐ Medication for any discomfort ☐ Anti-depressants ☐ HRT ☐ Vitamins
☐ Birth Control ☐ Other. Please list:

Medical Doctor's Name:

Family Health Profile

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

Mother: | Father:

Spouse: | Children:

Others:

Lifestyle Profile

What do you want to gain from Chiropractic Care?

What are your ultimate health goals/desired outcome?

What is your passion in life? Hobbies/Special interests.

For Women

Are you pregnant? ☐ Yes ☐ No ☐ Unsure | Date of last menstrual cycle:

Please ✓ if you have the following: ☐ Tender breasts ☐ Lumps in breast ☐ Period Discomfort ☐ Irregular periods

☐ Hot flushes ☐ Discomfort during intercourse ☐ Bleeding between periods ☐ Excessive menstrual flow ☐ Vaginal discharge

PLEASE READ AND SIGN

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to take 'specific postural x-rays' if required.

Patient's/Guardian's Signature: | **Date:**