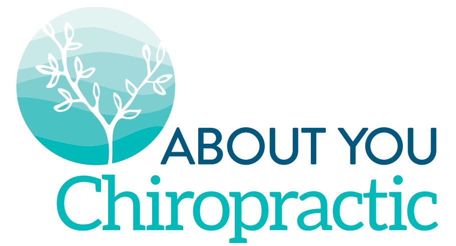
CONFIDENTIAL FIRST VISIT INFORMATION



PERSONAL INFORMATION

Name: (Mrs/Ms/Miss/Mr/Dr)

Date of Birth: Male Female

Address: Postcode:

Phone: Mobile Home Work *(best number to contact you on:* M W H *)*

Email:

Best time and place to contact you:

Marital status: Spouse / Partner name:

Children's names and ages:

Occupation: Interests / Hobbies:

We appreciate others telling you about Chiropractic. Who may we thank for referring you?

Emergency contact name: Number:

Relationship to you:

HEALTH CONCERNS

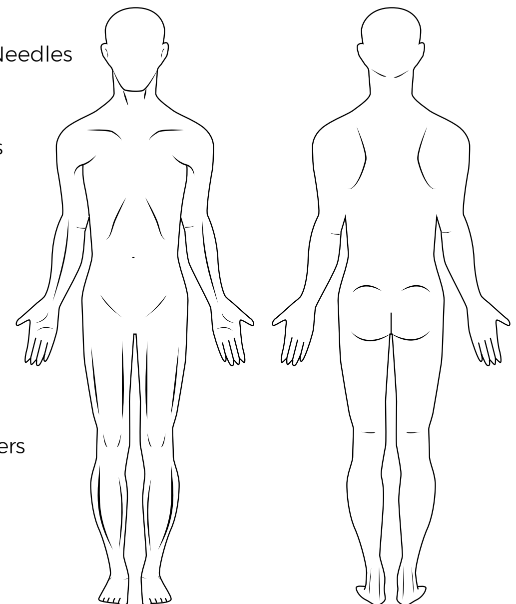
List your health concerns in order of priority	Rate of Severity *(1 = mild / 10 = very severe)*	When did this start?	If you have had this health condition before, when?	Did the problem begin with an injury?
1.				
2.				
3.				

Please mark on the image the type and location of your sensations right now.

A = Dull Ache | **S** = Sharp/Shooting/Stabbing | **N** = Numbness | **B** = Burning | **P** = Pins and Needles

Please check ALL your symptoms even if unrelated to your complaint:

- Pain at Night
- Leg Pain
- Arm Pain
- Bowel or Bladder Incontinence
- Unexplained Weight Loss
- Numbeness around Buttocks / Groin
- Pins and Needles in Legs
- Problems Urinating (Retention)
- Headaches
- Loss of Balance
- Mood Swings
- Numbness in Toes
- Cold Feet
- Back Pain
- Menstrual Irregularity
- Ulcers
- Lung Problems
- Diarrhoea
- Constipation
- Heartburn / Indigestion
- Fevers
- Hot Flushes
- Stomach Upsets
- Bleeding from the Bowel
- Sleeping Problems
- Light Bothers Eyes
- Ringing in the Ears
- Loss of Smell
- Loss of Taste
- Dizziness
- Irritability
- Fainting
- Nervousness
- Fatigue
- Depression
- Numbness in Fingers
- Neck Pain
- Weakness in Arms
- Weakness in Legs



What are your health concerns stopping you from doing? *Click on line below if filling out electronically.*

How are they affecting your everyday life? What are you not able to enjoy / have difficulty with? *Click on line below if filling out electronically.*

EXPERIENCE WITH CHIROPRACTIC

Have you been to a chiropractor before? Yes No If Yes: Who & When?

Have you ever had standing spinal Xrays taken? Yes No If yes: When & where?

Select which represents your reasons for care:

Wellness Prevention Feels Good Symptom Relief

MEDICAL HISTORY

Medical Doctor: Specialists / Alternative practitioners:

Do you give us permission to contact your GP to keep your health records complete? Yes No

Clinic Name:

Medications current and past 6 months and condition you are taking it for: *Click on line below if filling out electronically.*

Current vitamins / Supplements:

All previous surgery and year performed:

Physical traumas *(eg: Car accident, broken bones, sports injuries):*

Do you wear orthotics or heel lifts? Yes No

Check the conditions you have experienced

Drug addiction	Emphysema	Asthma	Pneumonia	Stroke
Alcoholism	Cold sores	Heart problems	Glandular fever	Allergies
Tuberculosis	High blood pressure	Attention deficit disorder	Migraines	Infertility
Cancer	Diabetes	Thyroid	Eczema	Menstrual issues
Osteoporosis	Anaemia	Arthritis	Circulation problems	

Please list significant family history *(eg: Osteoporosis, Rheumatoid Arthritis, Cancer, Scoliosis): Click on line below if filling out electronically.*

GENERAL HEALTH HISTORY

Stressors
Often the accumulation of life's stress can lead to health problems and influence our ability to function and heal. Please pay close attention to this as it will help us help you. We will speak to you about this further at subsequent visits. ***Tick any that apply to you.***

Physical / Postural Stress:
Grade overall Physical Health *(please circle/click on number):* *(Low)* 1 2 3 4 5 6 7 8 9 10 *(High)*

Forward head syndrome	Scoliosis	Sedentary (sitting) occupation	Falls	Major accidents
Round shoulders	Arthritis	Repetitive movement	Accidents	Other
Sleeping on stomach	Osteoporosis		Sporting trauma	

Biochemical Stress:
Grade overall Biochemical Stressors *(please circle/click on number):* *(Low)* 1 2 3 4 5 6 7 8 9 10 *(High)*

Smoking	High caffeine intake	Recreational drugs	Regular pain relief medication	Other
Unhealthy foods	Missed meal	Alcohol	On medications > 6 months	
High sugar intake	Don't drink enough water			

Emotional / Psychological Stress:
Grade overall Emotional Stress *(please circle/click on number):* *(Low)* 1 2 3 4 5 6 7 8 9 10 *(High)*

Work	Financial	Self esteem	Death	Other
Depression	Relationships	Sleep disturbances	Change in job	
Divorce	Anxiety	Grief	Family	

Are you as happy and healthy as you want to be? *(Low)* 1 2 3 4 5 6 7 8 9 10 *(High)*
(please circle/click on number):

EXERCISE

What exercise do you currently do?

DESCRIBE YOUR OWN BIRTH (IF KNOWN)

Describe your own birth (if known):

Drugs / medication used? Yes No
Forceps vacuum extraction? Yes No
Long or difficult labour? Yes No
Caesarean section? Yes No

As a baby / child did you:

Breast feed? Yes No
Frequent childhood illnesses? Yes No
Have colic/reflux? Yes No
Frequent antibiotics? Yes No

FOR WOMEN: PREVIOUS PREGNANCIES / BIRTHS

Number of previous pregnancies:
Number of previous births:

Location of births (please tick)
If > 1 birth please number in order of occurrence (eg: 1st child =1):

Home: Birth Centre: Hospital: Other:

Any medications used in previous pregnancies? Yes No

Any interventions used in previous births? Yes No
Please tick if Yes:

Induction	Forceps	Epidural	Prosten Gel
Breaking of waters	Episiotomy	Gas	C-section
Ventuse / Vacuum extraction	Physical force / Pulling	Syntocinon	Other

What was baby's presentation at delivery:

Head down	Frank Breech	Brow	Other
Footling Breech	Posterior	Facial	

At what gestational age was your baby/s born: 1 .

Was there any medical intervention needed for mum post birth/s. ie: stitches, transfusion? Yes No If yes please describe:

Was there any medical intervention needed for baby/s post birth? ie: Neonatal intensive care, comp feeding?

Any history of Post-Natal Depression? Yes No

Did you participate in chiropractic care during your previous pregnancies? Yes No

INFORMED CONSENT

Chiropractic is a well recognised, very safe and effective method of care for many conditions. Chiropractors complete a 5 year, fulltime university degree in order to become a registered practitioner. As with all healthcare professions, there is a small risk of injury, including, although not limited to; muscle and joint soreness, strains and sprains (to a ligament or disc; in the neck 1 in 139,000 or low back 1 in 62,000), fractures, strokes or stroke-like symptoms (1 in 5.85 million neck manipulations) and an exacerbation and/or aggravation of an underlying condition.

I hereby give consent to receive chiropractic care from a registered chiropractor and agree to undergo re-examinations including xrays if and when required.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment to this clinic.

Name: (Dependent)
Signature: (Guardian)

Chiropractor:
Date: