Adult Health History

Surname: _____ Given names: _____

Address: _____

Phone: Home: _____ Mobile: _____ Work: _____

Email: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Name of GP: _____

No. of children: _____ Occupation: _____ Employer: _____

How you heard about us:
○ Referred by existing patient: _____ ○ Google Search ○ Facebook
○ Event/Expo ○ GP ○ Word of Mouth ○ Midwife ○ Yellow Pages ○ Other: _____

Your nerve system controls and co-ordinates the function of your body. Please indicate any areas of concern:

- ○ Eye disorders
- ○ Sinus trouble
- ○ Ear disorders
- ○ Allergies
- ○ Asthma
- ○ Chronic cough
- ○ Loss of smell
- ○ Hay fever
- ○ Recurrent sore throats
- ○ Loss of taste
- ○ Headaches/migraines
- ○ Balance trouble
- ○ Sleeping problems
- ○ Dizziness
- ○ Stomach tension
- ○ Indigestion
- ○ Nausea
- ○ Vomiting
- ○ Constipation
- ○ Diahorrea
- ○ Abdominal pain
- ○ Urinary disorders
- ○ Bedwetting
- ○ Menstrual disorders
- ○ Tension - chronic
- ○ Irritability - chronic
- ○ Fatigue - chronic
- ○ Heart/blood pressure
- ○ Neck pain
- ○ Shoulder pain/stiffness
- ○ Arm pain
- ○ Loss of arm power
- ○ Pins & needles in hands
- ○ Loss of grip
- ○ Arthritis
- ○ Diabetes
- ○ Mid back pain
- ○ Pain in ribs/chest
- ○ Low back pain
- ○ Low back weakness
- ○ Low back stiffness
- ○ Hip pain or stiffness
- ○ Buttock pain
- ○ Leg pain
- ○ Leg cramps
- ○ Pins & needles in legs
- ○ Knee trouble
- ○ Foot trouble
- ○ Pins & needles in feet
- ○ Depression
- ○ Anxiety

Your reason for seeking our care: _____

How long have you had this complaint: _____

Is it: ○ Constant ○ Comes & goes ○ Getting worse ○ Getting better

Previous diagnosis and treatment for present complaint: _____

Other health problems: _____

List of surgery: _____

List of all accidents/falls: _____

_____

Are you taking any drugs/medicine/vitamins? Type and dosage: _____

_____

Exercise programme/sporting activities: _____

Any previous chiropractic care: By whom: _____ Last visit: _____

If you are female, is there a possibility you may be pregnant?: ○ Yes ○ No Breastfeeding?: ○ Yes ○ No

Signature: _____ Date: _____

If I choose to proceed with chiropractic care, I hereby authorise First Chiropractic and it's chiropractors to administer care as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office and I acknowledge that non-payment may result in my account and details being passed to a collections agency resulting in additional collection fees and charges.

first chiropractic
ADJUST • MAINTAIN • IMPROVE