FILE NO # _____

CAPACITY HEALTH ADULT PATIENT FORM

CHIROPRACTIC • HEALTH COACHING

SURNAME ..... GIVEN NAMES ..... DATE / /

WHO MAY WE THANK FOR REFERRING YOU? .....

YOUR FULL ADDRESS .....

POST CODE .....

HOME PHONE ..... MOBILE PHONE .....

EMAIL ..... IF YOU DO NOT WISH TO BE CONTACTED BY EMAIL, PLEASE TICK BOX ☐

AGE ..... BIRTHDATE / / SEX MALE ☐ FEMALE ☐ NO. CHILDREN .....

OCCUPATION ..... MARRIED ☐ SINGLE ☐ DEFACTO ☐ WIDOWED ☐

EMERGENCY CONTACT : NAME ..... RELATIONSHIP ..... CONTACT NUMBER .....

Current Health Concern

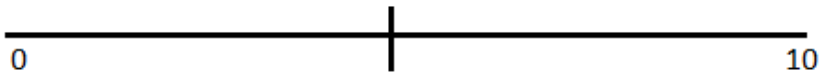
.....

.....

.....

☐*If there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box*

If pain is involved, rank it on a scale of 0 to 10



When did you first notice it?

.....

.....

What happened?

.....

.....

What relives it?

.....

What aggravates it?

.....

Does it radiate or cause problems elsewhere?

.....

.....

How is this impacting your quality of life presently?

.....

.....

Is it different now to how it was in the past? How?

.....

.....

Have you seen other professionals for this?

.....

.....

Treatment and results .....
Recent tests done .....

Do you think a full recovery is possible?
YES / NO

Do you think you will need to change some behaviours or habits to achieve the results in health you are after?
.....
.....

Any significant injuries, falls, vehicle accidents or traumas? If yes please explain
.....
.....

Any fractured bones or dislocations? .....

What is your average number of hours sleeping? .....

Do you fall asleep well? ☐ Yes ☐ No

Do you wake during the night? ☐ Yes ☐ No If so how many times? .....

How would you rate your energy levels out of 10?

None 1 2 3 4 5 6 7 8 9 10 Great

How much water do you drink? .....L/day

How much caffeine do you drink? E.g. Coffee, Tea, Coke & how many standard drinks of alcohol do you drink per week?

.....

Are you exposed to pollutants, chemicals, aerosols, odours etc?

.....

Are you taking any drugs, medications or supplements?
.....
.....

Who else do you use as part of your health team?
.....
.....

Please note any health issues that are <u>past</u> or <u>present</u> with family members such as parents, siblings, significant other or children. Eg: Cancer, Heart Disease, Diabetes
.....
.....
.....

Do you regularly exercise or move?
.....
.....

What are your favourite pastimes?
.....
.....

Can you remember a time when you had excellent health?
.....

What were you doing differently compared to now?

.....

Have you experienced any of the following (Tick appropriate box):

Past/Present	Past/Present	Past/Present
☐ ☐ Abdominal Pain	☐ ☐ Irritable Bowel Syndrome	☐ ☐ Low Back Pain/Stiffness
☐ ☐ Headaches	☐ ☐ Urinary Disorders	☐ ☐ Hip Pain or Stiffness
☐ ☐ Stroke	☐ ☐ Bed Wetting	☐ ☐ Buttock Pain
☐ ☐ Anxiety	☐ ☐ Menstrual Disorders	☐ ☐ Leg Pain
☐ ☐ Insomnia	☐ ☐ Sexual Disorder	☐ ☐ Leg Cramps
☐ ☐ Dizziness	☐ ☐ Chronic Fatigue Syndrome	☐ ☐ Vascular Problem
☐ ☐ Sinus Trouble	☐ ☐ Sleeping Problems	☐ ☐ Pins & Needles of Legs
☐ ☐ Ear Disorders	☐ ☐ Jaw/TMJ Problems	☐ ☐ Knee Trouble
☐ ☐ Hay Fever	☐ ☐ Soreness in Neck	☐ ☐ Foot or Ankle Trouble
☐ ☐ Recurrent Sore Throats	☐ ☐ Shoulder Pain/Stiffness	☐ ☐ Pins & Needles of Feet
☐ ☐ Asthma	☐ ☐ Arm Pain/Weakness	☐ ☐ Osteoporosis
☐ ☐ Chronic Cough	☐ ☐ Elbow Pain	☐ ☐ Arthritis
☐ ☐ Indigestion/Reflux	☐ ☐ Pins & Needles of Hands	☐ ☐ Diabetes
☐ ☐ Nausea/Vomiting	☐ ☐ Loss of Grip	☐ ☐ High Blood Pressure
☐ ☐ Allergies	☐ ☐ Wrist or Hand Pain	☐ ☐ Chronic Tension/Stress
☐ ☐ Constipation	☐ ☐ Mid Back Pain/Stiffness	☐ ☐ Loss of Taste
☐ ☐ Cancer	☐ ☐ Pain in Ribs	☐ ☐ Significant weight loss/gain in short time period
☐ ☐ Seizures	☐ ☐ Fertility Challenges	
☐ ☐ Swelling Legs	☐ ☐ Thyroid	☐ ☐ Colds
☐ ☐ Swelling Arms	☐ ☐ Prostate	

Other: ....

How motivated are you to change your health?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

PREGNANCY HEALTH HISTORY

** Please answer questions below if you are currently pregnant **

How many weeks pregnant are you? .....

Is this your first pregnancy?

.....

.....

Was you blood pressure prior to pregnancy within normal range, low or high? .....

What is your present blood pressure and when was it last checked? .....

Have you changed your diet since learning of your pregnancy? .....

Have you smoked prior to or along with this pregnancy? .....

Have you had alcohol during this pregnancy? .....