CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION



VERY COMMITTED

Marital Status: Post Code	Patient Name	FIRST NAME				Em	oloyer / Sc	hool				
Address Marital Status: Post Code					Occ	Occupation						
Partner's Occupation YOUR HEALTHCARE PROVIDERS GP Last Seen For Who may we thank for referring you? What brings you in today? What brings you in today? What brings you in today? If you are already experiencing a symptom, what is it? How bad is it? How intense are your symptoms? (circle) SYMPTOMS Please indicate main area of discomfort on diagram: Sharp pain = ##### Dull ache = XXXX Numbness/tingling = OOOO Other = ++++ = (Please specify sensation) IMPACT OF YOUR SYMPTOMS How is this symptom / condition interfering with your life? (check where appropriate) No Mild Moderate Severe North Mild Moderate Severe Work		THIS ELE TITLE				Ма	Marital Status:					
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VOUR HEALTHCARE PROVIDERS Call Phone	Home Phone					Par	tner's Occ	upation				
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Exercise		Effect										Effect
Recreation	Work					Energy						
Relationships	Exercise											
Sleep	Recreation											
	Relationships											
Self-Care LI LI Other D D D	Sleep						1					
	Self-Care			Ц	ш	Other		⊔				ш
How committed are you to correcting this issue?												

Date DD___MM___YY ___

NOT COMMITTED

		PATIENT WELLNESS ASSESSMENT					
	ILLNESS-	WELLNES	s co	NTINUUN	Л		
		COMFO	RT				
PRE- Dise	ase Developing ——	ZON		— Wellness D	eveloping -	HIGH-LEVEL	
DEATH		(FALSE WELL	.NESS)			WELLNESS	
0 1	2 3	4 5	6	7 8	9	10	
DISEASE	POOR HEALTH	NEUTRA	L	GOOD HI	EALTH	OPTIMAL HEALTH	
Multiple medications Poor quality of life	Symptoms Drug therapy	No sympto Nutrition incor	ms	Regular e Good nu	xercise	100% function Continuous development	
Potential becomes limited Body has limited function	Surgery Losing normal function	Exercise spo Health not a hig		Wellness ed Minimal nerve		Active participation Wellness lifestyle	
On the arrow diagram above:							
A. What number do you think re	epresents your health to	day?					
B. In what direction is your hea	25	5					
What are your health goals?							
IMMEDIATE (Next 6 months) _							
SHORT TERM (6 m - 5y)							
LONG TERM (5y - 20y)							
Children's ages?Children's names?			Health co	ncerns regarding	g this pregnar	TICK complete row belo	
HEALTH & ILLNESS	☐ Circulation Issue		O. 10. 100115	NO OCCUMENTATION ONE		TICK complete row belo	
☐ Alcoholism	☐ Childhood Illnes		☐ Headaches / Migraines☐ Heart Disease			D. Dinging in Fore	
☐ Anxiety	□ Depression		□ Heart	o .	s.	☐ Ringing in Ears	
				Disease	es	□ Ringing in Ears□ Scoliosis□ Shoulder Issues	
☐ Arteriosclerosis	Diabetes		☐ Heart☐ Hepat☐ Hip Is	Disease	es	□ Scoliosis	
	Digestive Issues		☐ Hepat	Disease	s	ScoliosisShoulder Issues	
□ Arthritis □ Asthma/Allergies	□ Digestive Issues (Constipation/Diarrhe	a/GERD/IBS)	☐ Hepat☐ Hip Is☐ Immu	Disease citis sues ne Issues hatic Issues	s	□ Scoliosis□ Shoulder Issues□ Stroke□ TMJ Issues□ Urinary Issues	
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□ Arthritis □ Asthma/Allergies □ Back Pain □ Cardiovascular Issues	☐ Digestive Issues (Constipation/Diarrhe	e/GERD/IBS) nd Issues es (Thyroid)	☐ Hepat ☐ Hip Is ☐ Immu ☐ Lympl ☐ Multip ☐ Neck	Disease titis sues ne Issues hatic Issues ble Sclerosis Pain	s	□ Scoliosis□ Shoulder Issues□ Stroke□ TMJ Issues□ Urinary Issues	
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HEALTH TRAUMA HISTO	ORY (include as much detail as possible	e.g. MM/YY, what happened, hospitalised?)
Motor Vehicle Accidents:		
106 1 2		
Work & sports trauma:		
Pregnancy Trauma:		
Trauma as Child:		
 Surgeries:		
Cargonico.		
Misc:		
*		<u> </u>
ALLERGIES, MEDICA	ATIONS & SUPPLEMENTS	
ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
LIFESTYLE HABITS	Indicate number in boxes below	
On average approx how many		
a)glasses wine, beer, alcohol/	week? glasses. b)cigarettes / day?	cigarettes. c)medical pills / day? pills.
d)supplement pills / day?	pills. e)hrs sleep / day? hours . f)s	essions of intense exercise / wk? sessions.
g) meals/snacks with fresh ve	getables/fruit per day? meals. h)gla	sses water / day? glasses.
FAMILY LIFALTIL DDO	FILE Main Francis Hardto Conditions	
Children	FILE Main Family Health Conditions	
,		
2 2		
Brother	Sister	

Thank you for carefully completing ALL the sections of your intake form. This helps you better achieve your health goals and it helps us make the best descisions for your care. Please carefully read and sign the consent form over.

Thank you for carefully completing ALL the sections of your official chiropractic intake & history form. Please carefully read and sign the consent form below.

CONSENT FOR A CHIROPRACTIC EXAMINATION & CARE

Extensive, prolonged, studies have show that qualified, well-trained chiropractors provide an extremely safe form of care.

Ethically, before starting your care, we need you to be informed of any risks so please read the following carefully.

Occasionally people under care experience mild healing effects and reactions such as muscle stiffness, local tenderness, tiredness, headaches, "flu-type" symptoms, release of emotions (such as crying) or dizziness. On very rare occasions 1 in 10,000 people report rib fracture. Whilst often reported anecdotally, serious injuries such as stroke are so extremely rare that they are reported as being less than 1 stroke per 2 million cervical adjustments. To put this into perspective, hospitalisations from the mildest of medical intervention such as a use of anti-inflammatory medications (e.g. Ibuprofen) are estimated at 40,000 per million (i.e. 80,000 times more likely) and deaths at 4000 per million (i.e. 8,000 times more likely), respectively.

In other words, receiving 80,000 adjustments has an equal risk to taking 1 ibuprofen pill.

Signed by Patient or parent/quardian:

I give consent to receive a chiropractic assessment which may include a non-intrusive thermal scan and a full hands-on examination at this practice.

If deemed appropriate by the Chiropractic Doctor I consent to receiving chiropractic adjustive care.

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Date:DD MM YY 20
Please only sign the next section after your second visit to the office
I have discussed with the chiropractic doctor the assessment of my condition and the care plan. I understand the nature of the care being provided to me. I have been informed of the benefits, risks and alternatives to chiropractic care. I hearby consent to receive chiropractic care as proposed to me.
Print N ame: Sign: