Romford & Ilford **Family Chiropractic Centre**

REGISTRATION,INFORMED CONSENT & HEALTH INFORMATION

PATIENT INFORMATION *(Please take your time & print clearly)*

Strictly Confidential

□ Married □ Widowed □ Single □ Minor

Name (surname) _____ □ Separated □ Divorced □ Partner

Name (first, middle)_____ Occupation _____

What do you preferred to be called? _____ Employer / School Address _____

Address _____ _____

Town / City _____ _____ Employer / School Phone _____

County _____ Postcode _____ Spouses Name_____

Home Phone _____

Mobile Phone _____ **IN CASE OF EMERGENCY**

Work Phone_____ Name_____ Relationship _____

Email _____ Home Phone _____ Mobile _____

Age_____ DOB _____ Sex □ M □ F How did you hear about us? _____

Hobbies _____ _____

Sports / Activities_____ **Whom may we thank for referring you?**

PATIENT CONDITION

Reason for Visit □ Spine & Nervous System Check-up □ Condition_____

Have you seen a Wellness Doctor / Spinal Specialist / Chiropractor before? _____

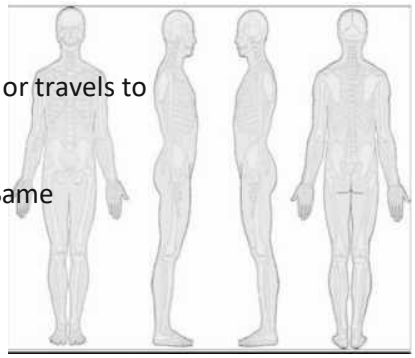
If there is a symptom, when did your symptom appear? _____

Rate the severity of your pain from 1-10 ***least*** 1 2 3 4 5 6 7 8 9 10 ***worst***

Today ☐ (score of 1-10) Best ☐ (score of 1-10)

Worst ☐ (score of 1-10) Average ☐ (score of 1-10)

Mark X on the picture where you get your pain and COLOUR where it radiates or travels to



Is it constant or does it come and go? _____

Is it worse in the morning or at night? _____

Is the condition getting progressively worse? □ Yes □ No □ Unknown □ Is the Same

What Aggravates your problem? _____

What Relieves your problem? _____

Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness
□ Burning □ Tingling □ Cramps □ Shooting
□ Stiffness □ Swelling □ Aching □ Other

What health care have you already received for your condition?

□ Chiropractic _____Date _____ □ Surgery _____ Date _____

□ Medications _____Date _____ □ Physical Therapy _____ Date _____

□ Other _____ _____Date ____

□ None_____

Injuries / Surgeries you have had

□ Falls _____ Date _____

□ Head Injuries_____ Date _____

□ Broken Bones _____ Date _____

□ Dislocations_____ Date _____

□ Surgeries _____ Date _____

The human body is designed to be healthy. Throughout your life, events occur which damage your health. This section will uncover layers of damage, especially to your Nervous System, that have resulted in your lowered state of health. TICK (√) THE APPROPRIATE BOXES THAT APPLY TO YOU.

	Yes		Yes		Yes
Nervousness	□	Shoulder stiffness/pain	□	Constipation	□
Poor sleeping	□	Pins & Needles in Arms	□	Diarrhoea	□
Epilepsy	□	Numbness in Finger	□	Menstrual Problems	□
Emotion problem	□	Cold Hands / Feet	□	Low Back Pain	□
Dizziness	□	Diabetes	□	Buttock Pain	□
Headaches	□	Loss of Smell/Taste	□	Hip joint pain / stiffness	□
Sinusitis	□	Colds/Flu	□	Slipped / Herniated disk	□
Migraines	□	Allergies	□	Thigh / Leg pain	□
Ear disorders	□	Mid back pain / stiffness	□	Knee Problems	□
Ear infections	□	Glaucoma	□	Pins & Needles in Legs	□
Jaw pain/clicking	□	Chest pain	□	Numbness in toes	□
Tonsillitis	□	Shortness of Breath/Asthma	□	Muscle Weakness	□
Recurrent sore throats	□	Rib pain	□	Sexual disorders	□
Neck tension/pain	□	Kidney pain	□	Testicular Pain	□
Neck stiffness	□	Hernias	□	Prostate troubles	□
Fainting	□	Poor Concentration	□	Ulcers	□
Ears Ringing	□	Fever / Cold Sweat	□	Frequent Urination	□
Loss of Balance	□	Light bothers eyes	□	Appendicitis	□
Loss of Memory	□	Fatigue	□	Cancer	□
Tension	□	Depression	□	High Blood Pressure	□
Irritability	□	Weight Problems	□	Bedwetting	□
Poor Co-ordination	□	Stomach/Digestive problem	□	Frequent injury in sport _	□

CURRENT HEALTH & WELLNESS

MEDICATIONS	ALLERGIES	SUPPLEMENTS
1._____	1._____	1. _____
2._____	2. _____	2._____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____

PREGNANCY

Are you currently pregnant? □ No □ Unsure □ Yes, and I am due _____ Number of past pregnancies _____

HEALTH QUESTION: What would it mean to you AND what would you like to achieve with better health?

_____

We do not accept any responsibility for the outcome of care provided in the event of any patients failing to adhere to their individually recommended care plan. This includes any care, services supplied by our centre.

Declaration: I confirm that the information provided in this form is true and correct to the best of my knowledge. I have read and understood the 'Informed Consent' form and agree to proceed an appropriate examination, an x-ray (if medically required) and I consent to Physiotherapy/Chiropractic/Massage care at Romford and Ilford Family Chiropractic Centre if recommended by the professional. Our privacy /complaints statement is available on request

Signed: _____ Date: _____

If under 18, I consent for _____ to receive chiropractic care.

Signature of parent/guardian: _____ Date: _____

HEALTH CONTINUUM

Illness-Wellness Continuum

Please circle where you think you are on the scale in terms of your health.

Disease

Multiple medications poor quality of life potential becomes limited body has limited function.

Poor Health

Symptoms: drug therapy surgery losing normal function.

Neutral

No symptoms nutrition inconsistent exercise sporadic health not A high priority.

Good Health

Regular exercise good nutrition wellness education minimal nerve interference.

Optimal Health

100 % function continuous development active participation wellness lifestyle.

Where do you see **your health now**?

You might be surprised!

Everyone has their own opinion about how healthy they are right now, but it can help to look at your health as not just physical health.
There's so much more to it:

Score yourself on a scale of 1 to 10 for all the following categories - we will then revisit this to see where you are. Score yourself out of 10 whilst you progress

Physical Health

What is your physical condition? Are you drinking plenty of water, receiving good nutrition, getting regular exercise and enjoying the proper weight for your height.

10

Mental Health

Are you open to new ideas? Do you seek out new experiences and learn new skills? What is the quality of the information and entertainment you allow into your mind?

10

Spiritual Health

How connected do you feel to a higher power in your life? Do you enjoy a sense of purpose and peace? Do you regularly study, meditate, pray or worship?

10

Career Health

Do you like what you do for a living? Does your career reflect and advance your deepest values? Is your work meaningful and suited to your skills and interests?

10

Social Health

How well do you interact with people? Are you able to maintain long term friendships? Are you comfortable in new social situations and in the company of others?

10

Family Health

Are you in a loving relationship with shared values? Do you give your family time and attention? Do you have a close connection with children, parents or relatives?

10

Financial Health

Are you living within your means? Is your debt within manageable limits? Do you make charitable contributions and save for the future? Are you properly insured?

10

TOTAL = ____ / 70