CHIROPRACTIC INTAKE & HISTORY

NORTHSIDE CHIROPRACTIC

CLIENT INFORMATION

SURNAME: _____.

FIRST NAME: _____. MIDDLE INITIAL: _____.

ADDRESS: _____.

SUBURB: _____. POSTCODE: _____.

HOME PHONE: _____.

MOBILE PHONE: _____.

EMAIL: _____.

SEX ☐ M ☐ F AGE: _____ BIRTHDAY: __/__/____.

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ PARTNERED ☐ MINOR

EMPLOYER/SCHOOL: _____.

OCCUPATION: _____.

SPOUSE'S NAME: _____.

IN CASE OF EMERGENCY, CONTACT:

NAME: _____.

RELATIONSHIP: _____.

CONTACT NUMBER: _____.

Who may we thank for referring you?

_____.

HOW CAN WE HELP YOU?

What brings you in today? _____.

_____.

If you are experiencing a symptom, what is it? _____.

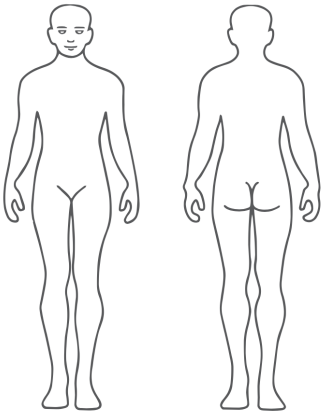
How bad is it? How intense are your symptoms? (circle) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Symptoms — Intense Symptoms

What does it feel like? (check all that apply)

- ☐ Numbness
- ☐ Sharp
- ☐ Tingling
- ☐ Shooting
- ☐ Stiffness
- ☐ Burning
- ☐ Dull
- ☐ Throbbing
- ☐ Aching
- ☐ Stabbing
- ☐ Cramping
- ☐ Swelling
- ☐ Nagging
- ☐ Other:_____.

Please circle areas below where you have pain or other symptoms:



IMPACT OF YOUR SYMPTOMS

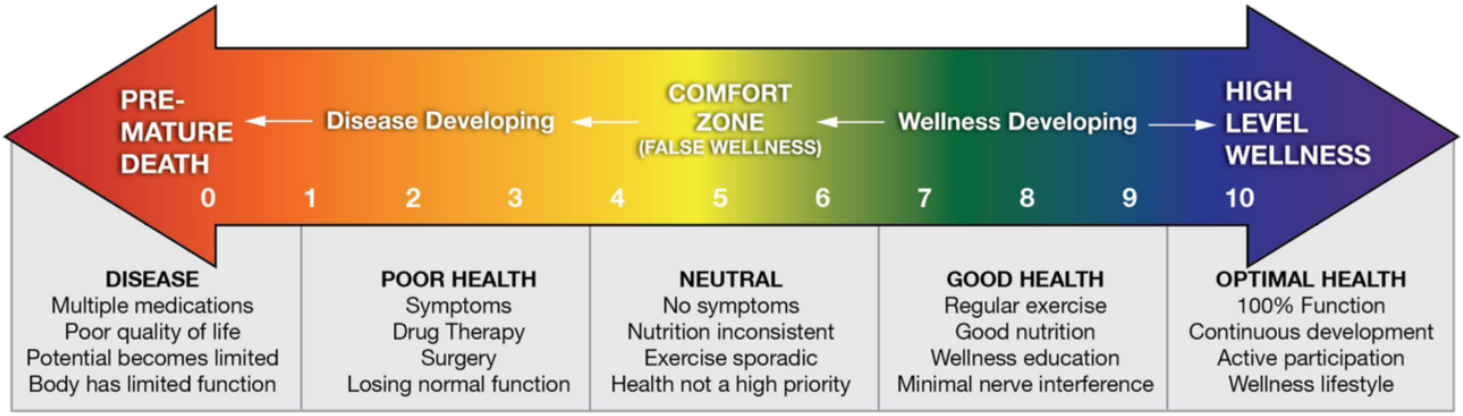
How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other:_____.	☐	☐	☐	☐

How committed are you to correcting this issue? (circle) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Not Committed — Very Committed

ILLNESS-WELLNESS CONTINUUM



On the diagram above:

A) What number do you think represents your health today?_____.

B) In what direction is your health currently headed?_____.

What are your health Goals?

Immediate: _____.

Short Term: _____.

Long Term: _____.

CHILDREN & PREGNANCY

How many children do you have?_____. Are you currently Pregnant? ☐ No ☐ Yes, Due:_____.

Childrens' ages?_____. Number of past pregnancies? _____.

Childrens' health concerns?_____. Health concerns for this pregnancy? _____.

HEALTH AND ILLNESS HISTORY

Check the box beside any condition you have, or have had.

☐ AIDS/HIV	☐ Circulation Issues	☐ Headaches/Migraines	☐ Ringing in Ears
☐ Alcoholism	☐ Childhood Illness	☐ Heart Disease	☐ Scoliosis
☐ Anxiety	☐ Depression	☐ Hepatitis	☐ Shoulder Issues
☐ Arteriosclerosis	☐ Diabetes	☐ Hip Issues	☐ Stroke
☐ Arthritis	☐ Digestive Issues	☐ Immune Issues	☐ TMJ Issues
☐ Asthma/Allergies	☐ Elbow/Wrist/Hand Issues	☐ Lymphatic Issues	☐ Urinary Issues
☐ Back Pain	☐ Endocrine Issues	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Cardiovascular Issues	☐ Foot/Ankle Issues	☐ Neck Pain	☐ Other:_____.
☐ Cancer	☐ Gout	☐ Reproductive Issues	_____.

ALLERGIES, MEDICATIONS & SUPPLEMENTS.

Allergies (list)	Medications (list)	Supplements (list)
_____.	_____.	_____.
_____.	_____.	_____.

Client Consent. At Northside Chiropractic we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know. I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns that they can be discussed with my chiropractor. I appreciate that I will receive the best care possible at Northside Chiropractic but that results cannot be guaranteed. I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time or service and cannot be deferred to a later date.

Client Signature:_____ Date:_____ Witnessed:

Northside Chiropractic provides an appointment reminder service by SMS and may also communicate with you by SMS and email from time to time. All clients are automatically enrolled in this service. If you do not wish to have this service please indicate below:

☐ Please do not send me appointment reminders and communications by SMS and email.