

Welcome to our Practice



Your body is designed to be healthy. On a daily basis, however, we experience physical, chemical and emotional stresses which can damage our health and quality of life. The effects are often gradual, accumulative and frequently are not felt until they become serious. The following questions will help uncover the layers of damage, especially to your nerve system, and may have resulted in poor health. At your next visit, your chiropractor will outline a course of care to begin to help correct these layers of damage and therefore allow an increase in your innate health potential.

PERSONAL DETAILS

Name _____ Preferred Name _____
Address _____ Tel # _____ (Home)
_____ Postcode _____ (Work)
Email Address _____ (Mobile)
Date of Birth _____ Age _____ Marital Status S M W D DeF
Occupation _____ No. of Children _____ Ages _____
Spouse/next of Kin _____

Your email address will be used to deliver the office newsletter. **Please provide the following details so we can establish you as a member of our website today:** Wellness Topics Diet & Nutrition Exercise & Fitness Stress Management

Children's Health Women's Health Issues Backaches & Sciatica Headaches & Neck Pain

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website. tick the box to opt out now

How did you hear about us?

Referred by another patient If so by whom? _____ Yellow Pages Local Trader
Signage/Walk by Internet Site? Which? _____
Organised Talk/Screening Advertisement Other? Please specify _____

Have you ever received chiropractic care? No Yes If So, when was your last adjustment?

From whom? _____ Where _____

HEALTH OBJECTIVES

People consult our practice with one or more of the following health objectives. Please indicate which apply to you

- Relief of symptoms Correction of my underlying problem
 To maximize my health To improve my family's health

HEALTH HISTORY

What are your reasons for consulting us?

How long have you had this? _____

Have you had this before Yes No If so, when? _____

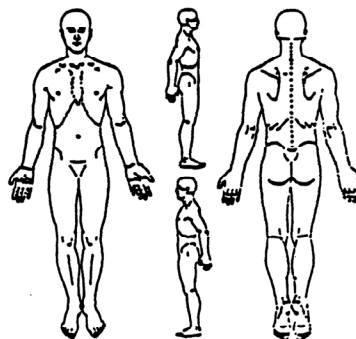
What activities make it worse? _____

Since this started, is it Unchanged Worsening Improving Intermittent

Have you consulted anyone else for this Yes No If yes, who? _____

When? _____ Treatment received _____

Please mark any areas of concern



Give details of any vehicle accidents or other impacts (including dates)

.....
List any surgical operation and years

.....
List any current medication and dosages

.....
List any major illnesses and years

Research shows that often the causes of health problems begin in the early years, some starting while still in gestation. Please answer the following questions to the best of your knowledge.

(FEMALES ONLY) - YOUR PREGNANCIES

During gestation..... Were you involved in any Injuries or accidents Were you ill or under undue stress
Was the delivery.... Particularly Long Particularly Rapid Neither
Did it involve..... Induced Labour Forceps/suction Breach Caesarian
A difficult delivery? Yes No At Home In Hospital

YOUR CHILDHOOD

Were you breast fed? Yes No
Did you suffer from Colic Bedwetting Earache/infections Throat infections
Other
Did you fall/jump from a height of over 1metre? (e.g. tree, bed, stairs) Yes No
Did you have the chair pulled from under you? Yes No

ADULTHOOD (please circle)

Do you smoke Yes No Drink tea/coffee Yes No Stressed? Yes No
Exercise regularly? Yes No
Drink alcohol Yes No Sleep well Yes No

Which sports/hobbies do you engage in

Indicate on the following scales (1-10) how you rate your

Pain/discomfort No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain
Health Poor 1 2 3 4 5 6 7 8 9 10 Excellent Health

CONSENT TO EXAMINE

Chiropractic care is recognised as being an effective and safe method of care for many conditions and ongoing wellness care. However, like any health care or medical/surgical procedure/ medication, there are some risks involved with chiropractic. Please sign below to acknowledge:

- That you are aware there rare risks associated with any proposed care which may include muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (approx. 1 in 5.85 million) and an exacerbation and/or aggravation of my underlying condition.

That you are aware of and understand the potential risks and appreciate that results are not guaranteed, but allow care to commence. You may withdraw your consent at anytime

I consent to Chiropractic Examination

Signed

Date:

I am under 16 years of old and my consent has been signed by

My parent

Legal guardian