Find Your Mojo

the natural way ™

chirohealth think chiropractor

Phase One

of your MojoQuest™

NAME

No:

DOB:

STAFF USE ONLY

PLEASE INDICATE THE CONDITIONS / SYMPTOMS YOU HAVE HAD OR DO HAVE...

✓ EXAMPLE

- HEADACHES
- INSOMNIA
- LOW ENERGY / FATIGUE
- POOR CONCENTRATION
- BRAIN FOG
- ANXIETY
- DIZZINESS
- LOW RESISTANCE TO DISEASE
- EARACHE
- HAYFEVER
- HEARING PROBLEMS
- SINUS PROBLEMS
- VISUAL PROBLEMS
- SLUGGISHNESS
- NIGHTMARES
- DIFFICULT TO TAKE A DEEP BREATH
- SHORTNESS OF BREATH
- ASTHMA
- BREATHING DIFFICULTIES
- HIGH / LOW BLOOD PRESSURE
- HEART CONDITIONS
- INDIGESTION
- HEARTBURN
- ACID REFLUX
- BELCHING
- TROUBLE WITH FATTY FOODS
- BLOATING
- FLATULENCE
- CONSTIPATION
- DIARRHOEA
- IBS
- ABDOMINAL CRAMPS
- KIDNEY INFECTION
- BLADDER INFECTION
- SWOLLEN ANKLES
- PMT
- PERIOD PAIN
- PROSTATE PROBLEMS
- LEG PAIN
- PINS & NEEDLES
- CRAMP IN LEGS
- SWOLLEN ANKLES
- REPRODUCTIVE PROBLEMS

PERSONAL DETAILS

PLEASE NOTE: THE DETAILS ENTERED ON THIS FORM ARE FOR OUR USE ONLY AND WILL NOT BE SOLD TO ANY THIRD PARTY.

First Name: _____ Surname: _____ Sex: _____

Marital Status: _____ Date Of Birth: _____ Age: _____

Occupation: _____ Height: _____ Weight: _____

Address: _____

_____ Post Code: _____

Tel (home): _____ Tel (mobile): _____

Your phone numbers are used to contact you regarding appointments or with information relating to your care/health

Email Address: _____

◯ Please tick if you are happy to receive test results or information relating to your care/general health via email

GP's Name & Address: _____

_____

How did you hear about us? ◯ Existing Patient Who may we thank for referring you to us? _____

◯ Advert ◯ Our Website ◯ Passing Clinic ◯ Other _____

Do you have private medical insurance? ◯ yes ◯ no Which Company? _____

WHAT IS YOUR NUMBER ONE PRIORITY?

- ◯ Improved posture & self esteem
- ◯ More energy & zest for life
- ◯ Reduced stress, increased optimism & improved sleep
- ◯ Less disease & sickness
- ◯ Increased productivity at work &/or home
- ◯ Improved co-ordination, balance & body confidence
- ◯ Reduced medications & pro-active natural healthcare
- ◯ Increased flexibility & pain reduction
- ◯ Improved fitness, strength & performance

MAIN REASON FOR VISIT: (i.e. low back pain, headaches, leg pain etc) _____

_____ When did it start? _____

HOW DID IT START?

- ◯ Accident
- ◯ Bending / twisting
- ◯ Gradually
- ◯ Lifting
- ◯ No cause
- ◯ Not sure
- ◯ Sports
- ◯ Suddenly
- ◯ Woke with it
- ◯ Other

TYPE OF PAIN

- ◯ Ache
- ◯ Burning
- ◯ Dull
- ◯ Numbness
- ◯ Pins and needles
- ◯ Sharp
- ◯ Stabbing
- ◯ Weakness
- ◯ Other

WHAT MAKES IT WORSE

- ◯ Bending
- ◯ Cold / damp weather
- ◯ Driving
- ◯ End of the day
- ◯ Heat
- ◯ Rest
- ◯ Lifting
- ◯ Mornings
- ◯ Rising from seated
- ◯ Prolonged sitting
- ◯ Prolonged standing
- ◯ Walking
- ◯ Other

WHAT MAKES IT BETTER

- ◯ Heat (wheat bag or bath)
- ◯ Ice
- ◯ Keeping busy / movement
- ◯ Massage
- ◯ Painkillers
- ◯ Other

IS IT...

- ◯ Constant
- ◯ Intermittent
- ◯ Up and down
- ◯ Good / bad days
- ◯ Getting worse
- ◯ Getting better
- ◯ Staying the same

RATE YOUR PAIN ON A SCALE OF 0 - 10
(0 = no pain, 10 = worst pain possible)

If 'Other' ticked at any point, please specify further: _____

What is the pain stopping you from doing? (e.g. work, playing golf, walking, lifting the grandkids etc.) _____

_____

Have you had treatment for this or similar problems? ◯ yes ◯ no Please give details: _____

_____

WOULD YOU LIKE US TO LOOK AT ANY OTHER PROBLEMS? (i.e. low back pain, headaches, leg pain etc) _____

_____ When did it start? _____

HOW DID IT START?

- ◯ Accident
- ◯ Bending / twisting
- ◯ Gradually
- ◯ Lifting
- ◯ No cause
- ◯ Not sure
- ◯ Sports
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THE FOLLOWING QUESTIONS ARE ABOUT YOUR GENERAL HEALTH: Please complete where applicable.

Do you currently smoke? ◯ yes ◯ no

Have you ever smoked? ◯ yes ◯ no When did you stop? _____

Do you drink alcohol? ◯ yes ◯ no How many units per week? ◯ 0-10 ◯ 11-21 ◯ 22+

Do you take regular exercise? ◯ yes ◯ no What activities? _____

Do you have children? ◯ yes ◯ no Ages? _____

Are you pregnant? ◯ yes ◯ no

When was your last period? _____

HAVE YOU HAD OR DO YOU HAVE:

- ◯ Allergies
- ◯ Ankle swelling
- ◯ Cancer
- ◯ Constipation
- ◯ Difficulty breathing
- ◯ Eczema / skin problems
- ◯ Grinding teeth
- ◯ High blood pressure
- ◯ Joint swelling
- ◯ Loss of vision
- ◯ Palpitations
- ◯ Prostate problems
- ◯ Teeth removed
- ◯ Anxiety / stress disorder
- ◯ Angina
- ◯ Chest pains
- ◯ Cystitis
- ◯ Difficulty urinating
- ◯ Epilepsy / seizures
- ◯ Headaches
- ◯ Indigestion / acid reflux
- ◯ Loss of balance
- ◯ Low blood pressure
- ◯ Period pains
- ◯ Rapid weight loss
- ◯ Varicose veins
- ◯ Arthritis
- ◯ Bladder infections
- ◯ Cold sweats
- ◯ Diabetes
- ◯ Dizziness
- ◯ Eye problems
- ◯ Heart attack(s)
- ◯ Irregular periods
- ◯ Loss of consciousness
- ◯ Numbness
- ◯ Pins and needles
- ◯ Sinus problems
- ◯ Visual disturbances
- ◯ Asthma
- ◯ Bloating / gas
- ◯ Chronic thrush
- ◯ Diarrhoea
- ◯ Eating disorder
- ◯ Fatigue / tiredness
- ◯ Hearing problems
- ◯ Jaw pain / clicking
- ◯ Loss of taste / smell
- ◯ Orthodontic work
- ◯ PMT
- ◯ Stroke / TIA

Have you ever had X-rays or MRI scans? ◯ yes ◯ no Please give details including dates: _____

_____

Are you currently attending hospital or seeing a specialist? ◯ yes ◯ no Please give details: _____

_____

THE FOLLOWING QUESTIONS ARE ABOUT YOUR GENERAL HEALTH: Continued...

Do you take any form of medication? ◯ yes ◯ no If yes, please detail below:		

Have you had any surgery? ◯ yes ◯ no If yes, please detail below:	
Surgical procedure:	Date of surgery:

Have you ever been involved in any accidents? Car, motorbike, push-bike, ladders, falls, slips, trips etc. ◯ yes ◯ no If yes, please detail:		
Type of accident:	Date of accident:	Injuries (broken bones / unconsciousness etc):

Has anyone in your immediate family ever suffered from: Cancer, Hepatitis, Diabetes, Tuberculosis, Epilepsy, Rheumatoid Arthritis or Stroke?

◯ yes ◯ no Please give details: _____

How long has it been since you last felt your best? ◯ years ◯ months ◯ weeks ◯ days

On a scale of 0 to 10 (0 being poor, 10 being excellent) Please describe your: Eating habits _____ Exercise habits _____

Sleep pattern _____ General health _____ Optimism _____ Posture _____ Energy levels _____ Happiness _____

PLEASE SIGN TO GIVE THE CHIROPRACTOR OR THERAPIST PERMISSION TO EXAMINE YOU

I, the undersigned, understand that a physical examination is required to determine my condition and I hereby give my consent to the examination.

SIGNED _____ **PATIENT / PARENT / GUARDIAN** **DATE** _____

THANK YOU FOR COMPLETING THE FORM. PLEASE RETURN TO THE FRONT DESK (do not fill out below until after your consultation)

PLEASE SIGN TO GIVE THE CHIROPRACTOR OR THERAPIST PERMISSION TO TREAT YOU

I, the undersigned, confirm that I have received and understood the information given to me regarding my presenting health complaint, the proposed treatment and its implications. I understand that the chiropractor(s) and therapist(s) will use their skills to improve my condition where possible. I hereby give my consent to treatment for the purpose of improving my health status and/or for the relief of symptoms.

SIGNED: _____ **PATIENT / PARENT / GUARDIAN** **DATE:** _____

PLEASE SIGN TO GIVE PERMISSION FOR THE RELEASE OF MEDICAL NOTES

I, the undersigned, give the clinic or practice permission to release my medical notes or detail their contents to the persons named below.

NAME: _____ **ADDRESS:** _____

SIGNED: _____ **PATIENT / PARENT / GUARDIAN** **DATE:** _____

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