Welcome Back to County Chiropractic

Our mission is to educate and adjust as many families as possible towards optimal health through natural chiropractic care. Misalignments of the body and nervous system are called subluxations and prevent the body from having optimal health. Please fill out this questionnaire as carefully as you can so that we can begin to assess your current level of health.

1.

Let us know if your **PERSONAL DETAILS** have changed– Please print clearly **Date:** ……

Forename (s): …… Surname: ……. Age:……

Full Address: …… ……

……...Post code…..……..

Telephone Numbers Home: ……... Work: ……

(Including STD code) Mobile: ……. E-Mail……

Marital Status: ……..…… Height: …… Weight:…..…….

Occupation: ……...……... Number of years in current occupation: ……...……..

Next of Kin?…….. Relationship?……contact no…….

GP's Name and Address: ……...

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2. YOUR CURRENT HEALTH

Do you have health concerns or symptoms? Yes / No

If you do not have specific symptoms and have come for a chiropractic check up please go to section 3

Please circle your main complaint:

Back pain, headache, sports injury, breathing, digestive

Eyes / ears, postural change,

Other health problems:……...…….

……

Please complete the diagram opposite ⇒ ⇒ ⇒ ⇒ ⇒

3. Since your last visit to County Chiropractic…

Have you had any illness?……..

Have you been hospitalised?…….

Started any medication?…….

Had any accidents / injuries?…….

How do you rate your current level of health?

Poor / fair / good / excellent

What are your health goals?……

……

……

What is your current exercise level? Low / moderate / High

Do you consider yourself fit YES / NO

Leisure / Sport / Hobby activities……

……..……

Do you consider your life stressful? YES / NO

How much water do you drink per day?……

How many portions of fruit / veg per day?……

If you have pain, on a scale of 0-10 in which box would you put your pain?

X at best **O** at worst = If both the same

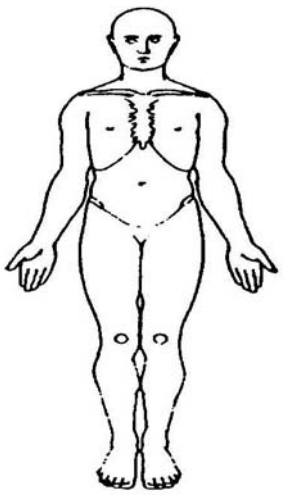
No Pain	1	2	3	4	5	6	7	8	9	10	Maximum Pain

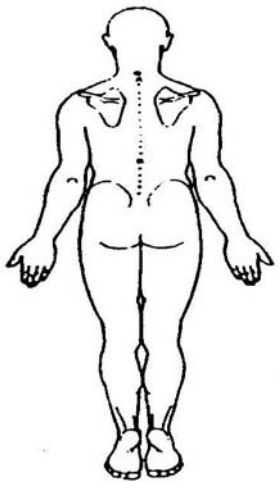
Please draw on the bodies below where your symptoms Are and the type of sensation, using the indicated Shading

XXX = Burning OOO = Tingling

/ / / / = Aching + + + = Stabbing

- - - - = Numbness





I have filled in this form to the best of my knowledge and I request a chiropractic examination and any appropriate treatment

Signed……..Date……...

(To be completed by the chiropractor)
Name _____ Pt No_____ Date_____

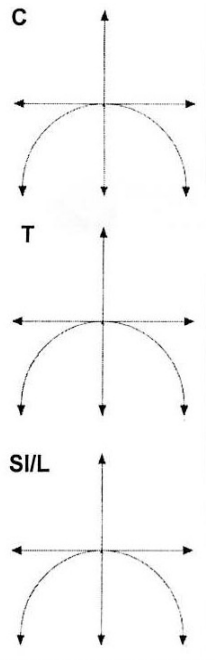
Primary Complaint

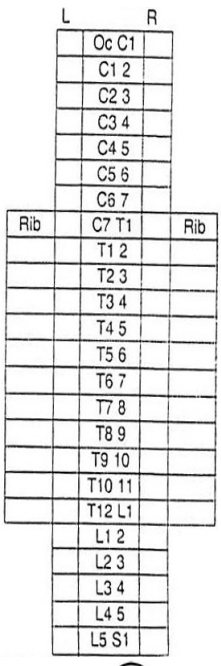
Associated symptoms

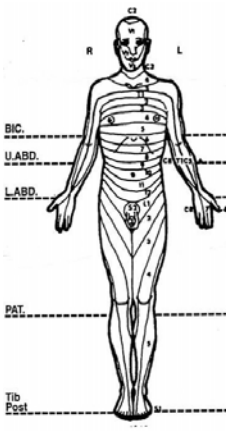
Systems Review (EENT, GI, GU, reproductive, CV)

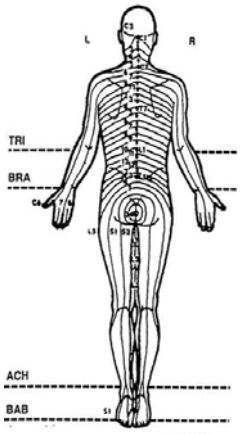
Sleep
Diet
Energy

Examination

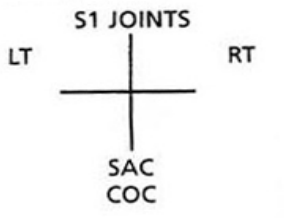








Diagnosis



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