

Welcome to our office

We endeavor to serve you in the best way possible so that your health outcomes are met. We ask that you assist us by completing the following information.



village
chiropractic
FAMILY WELLNESS CENTRE

Today's Date ___/___/20__

Title: _____ Last Name _____ First Name _____

Preferred Name _____

If Under 18 – Mother's Name _____ Fathers Name _____

Address _____

Suburb _____ P/Code _____

H.Phone ___-___-___ W.Phone ___-___-___ Mob.Phone ___-___-___-___

Email address: _____

Date of Birth ___/___/___ Age _____ Relationship Status _____

Occupation _____

Have you ever received chiropractic care? Yes No When? _____

From whom? _____ Did it help? Yes No Were x-rays taken? Yes No

Name of GP _____ GP Clinic _____

Partner's Name _____ Partner's Occupation _____

Names & Ages of Children _____

Referred by: Happy existing patient Name: _____
Another Practitioner Name: _____
Google
Flagstaff
Walked past
Spinal Screening
Other _____

Do you have Southern Cross private health care? Date if Renewal: ___ / ___ / ___
Do you require more information regarding private health in our office? Yes

Your History

Throughout your life you experience many stressors. Whilst some of these stressors may have seemed small, they often have an accumulative effect on our life. **Please answer** the following questions on the following areas of your life, which commonly arise during the formative years, to the best of your ability.

Pre- Pregnancy

Did your Mum and Dad...	Yes	No	Unsure
Plan and welcome the pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare their bodies for pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pregnancy

Did your Mum...	Yes	No	Unsure
Have chiropractic care during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise throughout pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a nutritious diet during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get injured during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke or drink alcohol during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endure Stress during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Birth Process

	Yes	No	Unsure
Home Birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Induced labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs during delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the delivery long?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the delivery difficult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caesarean (Elective/Emergency)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presentation position: Posterior, breech, correct, transverse, other (circle)			

Growth and Development

Physical

	Yes	No	Unsure
Physical abuse by siblings/others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violently pulled by arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you a head-banger?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you fall on your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you fall down stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you taught how to care for your spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have the chair pulled from under you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chemical

	Yes	No	Unsure
Were you breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken antibiotics? How many times? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you Vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mental/Emotional

	Yes	No	Unsure
Was there communication breakdown in your household?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there a loss of a close relative?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there any stress in the family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to any of the above, please give details			

Current Lifestyle

	Yes	No	Unsure
Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink adequate water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat healthy foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth healthy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sleep well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you physically stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you being, or have you been, exposed to chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sports: _____ Hobbies: _____

Have you been in a car accident/s before? Yes No When? _____

Other accidents: _____

Surgery: _____

Medications you take now: Blood Pressure Pain Killers Sleeping Pills Insulin Birth Control
 Sinus/Hayfever Cholesterol Thyroid Depression/Anti-Anxiety "The Pill"
 Other (please list) _____

Supplements you take now: Fish Oil Vit D Probiotics Magnesium Multi Vit Vit B CoQ10

Have you experienced a loss in the past 5 years? (e.g. relationship, family, business, financial)

Health Objectives

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

- Relief of my symptoms
- Correction of my underlying problems
- To maximize my health
- To maximize myself, my familys' and community health.

How would you rate your overall health? ___ / 10

What would you like your health to be? ___ / 10

Have you ever suffered from any of the following conditions: (please circle all that apply to you)

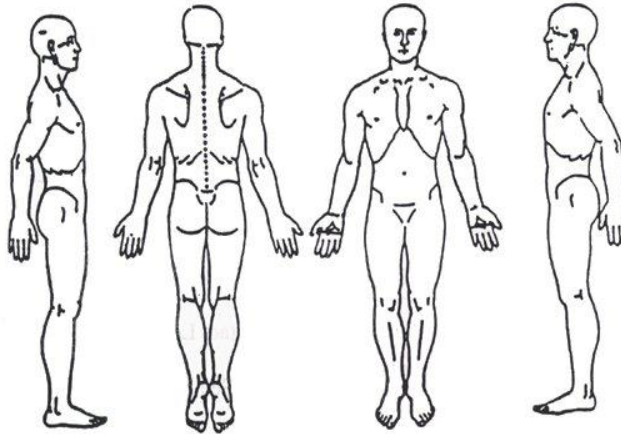
Dizziness	Fatigue	Headaches	Loss of sleep
Pain at night	Low back pain	Sciatica	Swollen Joints
Asthma	Frequent colds	Difficulty breathing	High blood pressure
Low blood pressure	Chest pain	Poor circulation	Anemia
Stroke	Pleurisy	Aids	Frequent urination
Prostate trouble	Lumps in breast	Diabetes	Cancer
Migraines	Loss of Libido	Sinus	Period Pain

Your Current Problem

You may have specific reasons for consulting this office. If so, please list below in order of severity?

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Please mark on diagram your areas of concern



Why do you think the problem started? _____

Was it the result of an accident Yes No Date: _____ Location: _____

Please describe any activities that may be causing these problems: _____

Does anything help relieve it? _____

Has it been **getting better**, **worse** or **staying the same** (circle)

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

Please rate your pain out of 10. _____ (**0 = no pain, 10 = worst pain**)

What type of pain is it? (e.g. burning, stabbing, aching) _____

Does the pain travel anywhere? Yes No If so where to? _____

Tingling in either arm or leg? Yes No If so where to? _____

Numbness in either arm or leg? Yes No If so where to? _____

Weakness in either arm or leg? Yes No If so where to? _____

Is the pain **constant** or **off/on**? (circle)

Is it worse in the **morning**, **lunchtime**, **afternoon**, **evening**, or **when you sleep**? (Please circle all that apply to you)

Have you seen anyone else for these problems? Yes No
If yes, who? _____ when? _____

What are these problems stopping you from doing or achieving?
(e.g. walking, working, sport, travel, family time, relaxing, hobbies)

1. _____
2. _____
3. _____