Spinal Care Chiropractic Inc.
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Practice Member Information

Date: _____
Name: _____ Gender: □ M □ F
Birthdate: _____ DD _____ MM _____ YYYY Age: _____
Home Address: _____
Home Phone: _____ Work Phone: _____ Mobile: _____
Email Address: _____ Do you want to subscribe to the newsletter? □ N □ Y
How did you hear about us? □ Website □ Facebook □ Google □ Referred by: _____

Lifestyle Profile

Exercise, Sports & Stretching

Do you go to the gym? □ N □ Y**,** do you have a personal trainer? □ N □ Y
What exercises are you currently doing? Tick all that applies:

□ Walking	□ Push-ups	□ Leg Press
□ Weights	□ Crunches/ Sit-ups	□ Lunges
□ Crossfit	□ Yoga	□ Squats
□ Dead Lifts	□ Pilates	□ Cycling
□ Leg Raises	□ Zumba	□ Running
□ Planks	□ Kettlebell	□ Swimming
□ Others (please specify):		

Do you engage in any sports/ leisure activities? □ N □ Y, please specify: _____
Do you do flexion stretches (bending forwards, knee to chest)? □ N □ Y

Sitting Posture

How many hours do you sit per day? □ 0-4 □ 5-8 □ 9-12 □ 13+
How many hours do you spend on a smart device (mobile phone/ tablet) per day? □ 0-2 □ 3-5 □ 6+
What mode of transport do you often use? □ Private Car □ Motorcycle □ Public Transport □ Airplane
Tick all that applies to you:

□ I sit for more than 1 hour without a break	□ I sit on a reclined car seat/ plane seat
□ I sit with both legs on top of a table/ chair	□ I sit on the bed (to watch TV, use laptop or read)
□ I sit in an “Indian sitting” position	□ I use a height adjustable chair
□ I sit with legs crossed	□ I use a standing desk
□ I sit with my wallet/ phone in my back pocket	□ I use a laptop more than desktop
□ I sit upright against the backrest of the chair	□ I use a pillow/ lumbar support
□ I sit on a soft sofa/ chair or La-z-boy	□ The middle of my desktop monitor is at eye level
□ I sit on the floor	□ I breastfeed my child *(female only)*

Standing Posture

Do you slouch/ hunch over when you stand? □ N □ Y
Do you regularly carry a backpack? □ N □ Y
Do you carry your bag on one shoulder or arm/hand? □ N □ Y
Do you often wear high heels or footwear with no arch support? □ N □ Y

For people taking care of small children

Do you carry a child for extended periods of time? □ N □ Y, do you use a baby carrier? □ N □ Y
Do you carry the child on your shoulder or back (piggy-back)? □ N □ Y
Do you often hunch over to pick up the child or assist them in walking? □ N □ Y

Sleeping Posture

How many hours do you sleep? □ 0-4 □ 5-8 □ 9+

Tick all that applies:

□ I sleep face down	□ I sleep with 1 pillow	□ I sleep on my shoulder
□ I sleep on my back	□ I use soft pillow/s	□ I sleep on my side with the top leg crossed over
□ I sleep on my side	□ I use a soft mattress	□ When I sleep, I stay in 1 position the whole night

Healthcare History

Have you had previous chiropractic care? □ N □ Y, Where? _____ When? _____

Do you have any medical conditions? □ N □ Y, _____

What medications do you regularly take? □ NSAIDs □ Others: _____

What supplements do you take? □ DHA □ Probiotics □ Vitamin D3 □ Multivitamin □ Others: _____

Have you had any surgeries? If so, what was it for and when? _____

Have you had any accidents or trauma as a child/ adult? _____

Do you have excessive amount of stress in your life? □ N □ Y, do you handle stress well? □ N □ Y

Wellness Profile

Why are you seeking Chiropractic Care?

□ Relief Care – Short term relief of symptoms

□ Corrective Care – Correcting and stabilizing the spine and addressing postural issues

□ Wellness Care – Optimizing health and prevention of spinal degeneration

Do you have a specific concern that brings you in? □ N □ Y, _____

_____

_____

_____

_____

_____

When did it start? _____ How often? □ Daily □ Weekly □ Monthly □ On/Off □ Constant

On a scale of 1-10 (10 being the worst), how does it feel when it is at its worst? _____

How would you describe the pain? □ Dull □ Achy □ Throbbing □ Stabbing □ Tight/Stiff □ Burning □ Sharp

What makes it better? _____ What makes it worse? _____

Is your condition is progressively getting worse? □ N □ Y

How does this affect your daily life? _____

What treatments have you tried? □ Heat □ Ice □ Medication □ Self-manipulation □ Massage □ Physical Therapy □ Chiropractic □ Acupuncture □ Surgery □ Others:_____

Goals and Consent

What are your health goals? _____

Are you willing to change your lifestyle to reach your health goal? □ N □ Y

Our goals are to provide a detailed assessment of your current heath status, provide you a guide to a sustainable approach to reaching your health goals and achieving a healthy nervous system.

I, _____ hereby grant permission to receive a chiropractic evaluation including history, postural analysis, and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

For Office Use Only □ Video □ Posture Photo □ MRI □ Previous X-Ray □ Others: _____