

Adult New Patient Medical History

Surname: _____ Age: _____

Forename(s): _____ Preferred Name: _____ DOB: _____

Address: _____

Home Tel: _____ Work Tel: _____

Mobile: _____ Email: _____

Occupation: _____

Marital Status: S M D W Partners Name: _____

Names of Children & Ages _____

Name and Practice of GP _____

Have you ever received Chiropractic care? Yes No Please tick

Why are you here? _____

How did you hear about Sensus Health & Wellness? _____

Your body is designed to be healthy. There is always a cause or reason to why it is not. Throughout life many events occur that may damage your health.

The following questions will help us assess any layers of damage, particularly to your nervous system, that have adversely affected your health. All information will be handled in the strictest of confidence. Please tick where appropriate.

Your Birth

The birth process can be quite traumatic on both mother and baby and is often where spinal damage may first occur. Was your birth:

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> Unassisted | <input type="checkbox"/> Forceps/Suction | <input type="checkbox"/> Caesarean | <input type="checkbox"/> Short duration |
| <input type="checkbox"/> Premature | <input type="checkbox"/> Induced | <input type="checkbox"/> Breech | <input type="checkbox"/> Drug assisted |
| <input type="checkbox"/> Prolonged labour | <input type="checkbox"/> Unsure | | |

Your Childhood

Children often display symptoms of decreased health that may stem from spinal problems and/or nerve pressure. As a child did you suffer from:

- | | | | |
|--------------------------------------|---|---|----------------------------------|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Tonsillitis/throat infection | <input type="checkbox"/> Other |

As a child were you:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> A restless sleeper | <input type="checkbox"/> A head banger |
|-------------------------------------|---|--|

As a child did you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Have any major accidents | <input type="checkbox"/> Have surgery | <input type="checkbox"/> Require medication (prescribed/other) |
| <input type="checkbox"/> Crawl before walking | <input type="checkbox"/> Use a baby walker | <input type="checkbox"/> Use a baby bouncer |
| <input type="checkbox"/> Sleep on your stomach | <input type="checkbox"/> Fall down stairs | <input type="checkbox"/> Use calipers |
| <input type="checkbox"/> Have flat feet | <input type="checkbox"/> Have turned feet | <input type="checkbox"/> Have a chair pulled from under you |

Were you vaccinated as a child: yes no unsure

Women Only

Reproductive issues can place a strain on your body's resources. Chiropractic can help redress the balance. Have you had/Do you have:

- | | | | |
|---|------------------------------|---|---|
| <input type="checkbox"/> Period pain/discomfort | <input type="checkbox"/> PMT | <input type="checkbox"/> Irregular period's | <input type="checkbox"/> Chronic thrush |
|---|------------------------------|---|---|

Have you experienced any fertility problems (please give details)? _____

Number of full term pregnancies _____ Number of pregnancies not to term _____

Have you experienced any problems throughout pregnancy (please explain) or with the birth (give details) _____

Have you been on the oral contraceptive pill? yes for how long _____ no

Accidents

Have you ever suffered:

- | | | | |
|---------------------------------------|-----------|---|-----------|
| <input type="checkbox"/> Broken bones | Age _____ | <input type="checkbox"/> Motor vehicle accidents | Age _____ |
| <input type="checkbox"/> Sprains | Age _____ | <input type="checkbox"/> Fainting/Unconsciousness | Age _____ |
| <input type="checkbox"/> Other | Age _____ | | |

Please give details: _____

As the core problems get coated with more and more layers of damage, symptoms and bouts of sickness arise, displaying decreasing adaptability and health.

General Health

Have you ever suffered from an illness that required hospitalisation or long-term medication?

Describe _____ Age _____

Do you take any medication/drugs (prescription/non prescription)

Medication: _____ What for _____ How long? _____
Medication: _____ What for _____ How long? _____
Medication: _____ What for _____ How long? _____
Medication: _____ What for _____ How long? _____

Have you ever had surgery either as a child or an adult?

Tonsils Appendix Adenoid's Hysterectomy
 Other (please give details) _____

Have you ever had x-rays, scans or MRI (Please give dates and details)? _____

Have you had/Do you have:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Cystitis/bladder infections	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Eye problems
<input type="checkbox"/> Heart attacks/angina	<input type="checkbox"/> Loss of smell/taste	<input type="checkbox"/> Arthritis/joint swelling
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Jaw pain/clicking	<input type="checkbox"/> Asthma	<input type="checkbox"/> Strokes/T.I.A.'s
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Pins and needles	<input type="checkbox"/> Fatigue/tiredness	<input type="checkbox"/> Orthodontic work
<input type="checkbox"/> Allergic reactions	<input type="checkbox"/> Numbness	<input type="checkbox"/> Diarrhoea & constipation
<input type="checkbox"/> Teeth removed	<input type="checkbox"/> Eczema/skin problems	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Cancer	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Epilepsy/fits/seizures
<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Rapid weight loss	<input type="checkbox"/> Difficulty urinating
<input type="checkbox"/> Other		

Do you suffer with:

Occupational Stress Physical stress Mental stress

Nutrition

Do you:

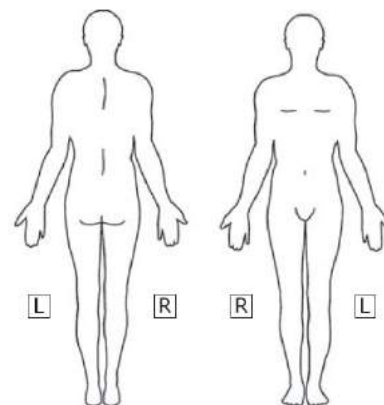
Smoke: yes no Number per day? _____
Drink alcohol: yes no Glasses (not pints) per week? _____
Drink water: 0-1 glass per day 1-3 glasses per day 4-8 glasses per day more

Eat *fresh* vegetables: 0-3 servings per week at least 1 per day several per day
Eat *fresh* fruit: 0-3 servings per week at least 1 per day several per day

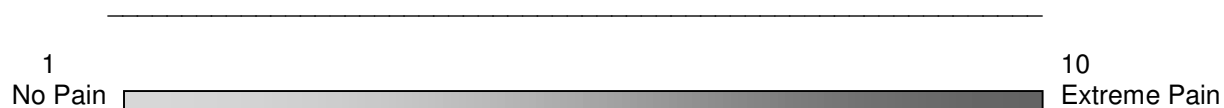
Is there a family history of:

	Heart disease	Arthritis	Cancer	Diabetes	Other
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you suffering any pain or illness conditions at the moment?
Describe them and indicate areas on the diagrams



Indicate on the following scale how you would rate your pain/discomfort on a scale of 1-10:



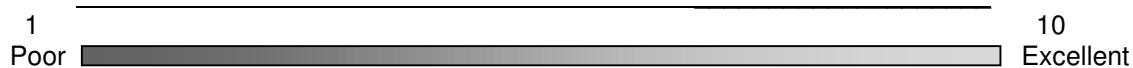
Which sports, hobbies or leisure activities do you engage in: _____

What is your sleeping posture? Side Stomach Back

Number of hours of quality sleep per night _____

How many pillows do you use? _____ How old is your mattress? _____

On a scale of 1 – 10 how would you rate your health?



Reasons: _____

