

# YOUR INTAKE & HEALTH HISTORY

## YOUR INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

My Occupation \_\_\_\_\_

Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Postcode \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_

GP Name \_\_\_\_\_

Mobile Phone \_\_\_\_\_

GP Surgery \_\_\_\_\_

Email \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Sex  M  F Age \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name \_\_\_\_\_

Married  Widowed  Single

Relationship \_\_\_\_\_

Separated  Divorced  Partnered

Contact Number \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## HOW CAN WE HELP YOU?

What brings you in today? \_\_\_\_\_

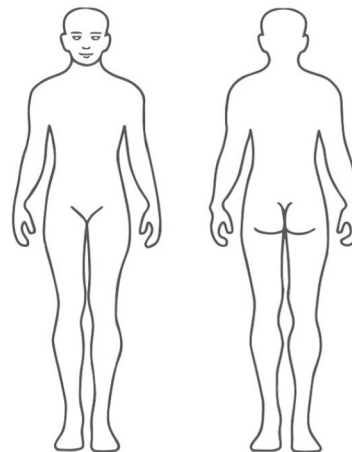
If you are already experiencing a symptom, what is it? \_\_\_\_\_

How bad is it? How intense are your symptoms? (circle)  0  1  2  3  4  5  6  7  8  9  10  
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas on the body to the right where you have symptoms:

What does it feel like? (tick where appropriate)

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sharp       |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Shooting    |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning     |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stabbing    |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Swelling    |
| <input type="checkbox"/> Nagging   | <input type="checkbox"/> Other _____ |



## IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (tick where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?  0  1  2  3  4  5  6  7  8  9  10  
NOT COMMITTED VERY COMMITTED

# YOUR WELLNESS ASSESSMENT

## ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONG TERM \_\_\_\_\_

**DIET:**

How much water do you drink per day? \_\_\_\_\_

How many cups of tea/coffee do you drink per day? \_\_\_\_\_

How many portions of fruit/veg do you eat per day? \_\_\_\_\_

## CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_

Childrens' ages? \_\_\_\_\_

Childrens' health concerns? \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues                                   | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears          |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis                |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues          |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> Jaw pain/aching/clicking |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Urinary Issues           |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Osteoporosis             |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues                                    | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Cancer                |   | <input type="checkbox"/> Reproductive Issues   | _____   |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

SUPPLEMENTS \_\_\_\_\_

## CONSENT TO EXAMINATION

Do you consent to your GP being contacted if required?  Yes  No

**Please read and sign below**

**I consent to a chiropractic physical examination today. I understand that the chiropractor may begin my care today if it is appropriate to do so. I also understand that a report of the findings from this examination will take place on my second visit.**

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_