Wellness & Vitality

CHIROPRACTIC

Welcome to Wellness & Vitality Chiropractic

The purpose of this practice is to help people get well and stay well.

New Patient Personal Information

Full Name:	
How do you wish to be addressed?	
Address: Postcode:	
Home phone:	Work phone:
Mobile phone:	Email address:
Date of birth:	Age:
No of children: What are their ages?	(**Female patients only**) Could you be pregnant? Yes No Date of last menstrual period:
Marital status: M S W D CP	Occupation:
Emergency Contact Name/Number:	
Who may we thank for referring you?	
I understand that I am liable for fees incurred and that payment is at the time of service. Signed: Date:	
GP:	Surgery Address:
From time to time, it may be necessary to contact your doctor to discuss your progress. This will not be done without your knowledge. Do we have your consent to do this? Yes No	

People come to see us for a myriad of reasons so it is very important to us at **Wellness & Vitality Chiropractic** that you understand how we can help and what we do and don't do.

Whilst Chiropractic is very good at alleviating pain and symptoms, it does not **cure** anything. The only person that can cure you is you. You are self-healing and self-regulating. This happens through your nervous system which connects your brain to your body. The better connected your nervous system, the better your body will function. Chiropractors work on your spine to remove interference from your nervous system. Diet and exercise are also essential ingredients to a healthy body and mind.

With the above in mind, please complete the rest of the form as accurately as possible. This will enable us to get a better understanding of your health history and how best to help you.

What are your goals in coming to Wellness & Vitality Chiropractic?

☐ **Relief of symptoms only**
Generally, this is a short intensive course of treatment. 3-12 weeks depending on your history.

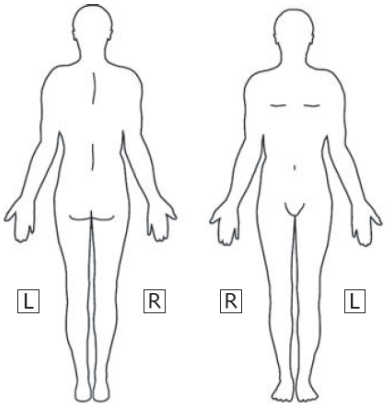
☐ **Rehabilitation**
This is a moderate term of care aimed at improving your symptoms and then allowing the body to heal more effectively by supporting proper function with the addition of strengthening exercises.

☐ **Maintenance**
Rehabilitation care followed by regular checks to reduce the chance of the reoccurrence of symptoms.

☐ **Wellness**
Regular checks, regardless of symptoms, to facilitate better neurological function and thus improve the innate healing abilities of the body. This also includes taking responsibility for lifestyle choices such as diet, rest, and exercise.

Health Concerns

What is/are the main reason(s) for coming today?



Please list your health concerns according to their severity and indicate areas on the diagram	How long have you had this problem?	Rate of severity 1 = mild 10 = extreme
1		
2		
3		
4		

How would you describe the pain? (Please circle all applicable ones)

Dull Aching Numb Sharp Stiff Tingly Burning Throbbing Stabbing

What aggravates the pain? _____

What relieves the pain? _____

Have you seen anyone regarding this complaint(s)? Yes ☐ No ☐

Who? _____

Was it helpful? Yes ☐ No ☐

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

1 No Pain — 10 Extreme Pain

General Health History

Accidents

Have you had **ANY** of the following? If yes, describe briefly

Vehicle Accident	When?	Hospitalized? Yes ☐ No ☐
Broken/dislocated bones	When?	Hospitalized? Yes ☐ No ☐
Falls or knocks (accidental or sports related)	When?	Hospitalized? Yes ☐ No ☐

Surgery

Have you had **ANY** surgery? (Please note ALL surgery even if you might not think it relevant)

What?	When?
What?	When?
What?	When?
What?	When?

Medication

Please list **ANY** medications/drugs you are currently taking (prescription/non-prescription):

	What for	Dosage
	What for	Dosage
	What for	Dosage
	What for	Dosage

Please mark any of the following conditions that you may have had or have now:

Neck pain/ Stiffness ☐ Current ☐ Past	**Arm/Hand pain** ☐ Current ☐ Past	**Arm/Finger/ Hand Weakness** ☐ Current ☐ Past	**Pins & Needles in Arms/Hands/Fingers** ☐ Current ☐ Past	**Shoulder Pain/ Tightness** ☐ Current ☐ Past	**Pain Mid-Spine** ☐ Current ☐ Past
Chest Pain ☐ Current ☐ Past	**Pain/Restricted Breathing** ☐ Current ☐ Past	**Heartburn/ Reflux** ☐ Current ☐ Past	**Nausea/Vomiting** ☐ Current ☐ Past	**Constipation/ Diarrhoea** ☐ Current ☐ Past	**Asthma** ☐ Current ☐ Past
Allergies ☐ Current ☐ Past	**Lower Back Pain** ☐ Current ☐ Past	**Hip Pain/Stiffness** ☐ Current ☐ Past	**Pins & Needles in Legs/Feet** ☐ Current ☐ Past	**Leg Weakness** ☐ Current ☐ Past	**Leg Pain** ☐ Current ☐ Past
Buttock Pain ☐ Current ☐ Past	**Pain standing/ sitting** ☐ Current ☐ Past	**Groin Pain** ☐ Current ☐ Past	**Nervousness** ☐ Current ☐ Past	**Depression/ Anxiety** ☐ Current ☐ Past	**Tension/ Irritability** ☐ Current ☐ Past
Fatigue ☐ Current ☐ Past	**Sleeping/Snoring Problems** ☐ Current ☐ Past	**Light bothers eyes** ☐ Current ☐ Past	**Loud Noises Irritate** ☐ Current ☐ Past	**Hearing Problems** ☐ Current ☐ Past	**Tinnitus/ Ringing in Ears** ☐ Current ☐ Past
Headaches ☐ Current ☐ Past	**Migraine** ☐ Current ☐ Past	**Stroke** ☐ Current ☐ Past	**Blood Pressure High/Low** ☐ Current ☐ Past	**Fainting** ☐ Current ☐ Past	**Dizziness** ☐ Current ☐ Past
Blurred/ Double Vision ☐ Current ☐ Past	**Loss of Balance** ☐ Current ☐ Past	**Slurred Speech** ☐ Current ☐ Past	**Difficulty Finding Words** ☐ Current ☐ Past	**Words Round Wrong Way** ☐ Current ☐ Past	**Cold Feet/Hands** ☐ Current ☐ Past
Sweat a lot ☐ Current ☐ Past	**Varicose Veins/ Hemorrhoids** ☐ Current ☐ Past	**Tearing/Dry Eyes** ☐ Current ☐ Past	**Difficulty Swallowing** ☐ Current ☐ Past	**Face Pain** ☐ Current ☐ Past	**Jaw Pain/ Clicking** ☐ Current ☐ Past
Loss of Smell ☐ Current ☐ Past	**Loss of Taste** ☐ Current ☐ Past	**Kidney Pain** ☐ Current ☐ Past	**Frequent Urination** ☐ Current ☐ Past	**Incontinence** ☐ Current ☐ Past	**Bedwetting** ☐ Current ☐ Past
Prostate Trouble ☐ Current ☐ Past	**Testicular Pain** ☐ Current ☐ Past	**Sexual Dysfunction** ☐ Current ☐ Past	**Uncontrolled Shaking/Movement** ☐ Current ☐ Past	**Twitching Muscles** ☐ Current ☐ Past	**Restless Legs** ☐ Current ☐ Past
Leg Cramps ☐ Current ☐ Past	**Epilepsy** ☐ Current ☐ Past	**Recurrent Fever** ☐ Current ☐ Past	**Recurrent Colds/ Flu** ☐ Current ☐ Past	**Diabetes** ☐ Current ☐ Past	**Cancer** ☐ Current ☐ Past
Night Sweats ☐ Current ☐ Past	**Excessive Weight Gain/Loss** ☐ Current ☐ Past	**Loss of Memory** ☐ Current ☐ Past			

Have you had any x-rays or scans of your spine? Yes ☐ No ☐

If so, what area and when?

_____

Do you have any conditions you have been told to "live with"? Yes ☐ No ☐

What?

_____

Is there any family history of illness? Yes ☐ No ☐

What?

_____

_____

_____

Have you ever suffered from an illness which required hospitalization or long-term medication?

_____

_____

When? _____

Nutrition/Fitness

Do you:

Smoke: Yes ☐ No ☐ Number per day? _____

Drink alcohol: Yes ☐ No ☐ Glasses (not pints) per week? _____

Do you exercise or play sport? If so what and how often? What hobbies or leisure activities do you engage in?

_____

_____

_____

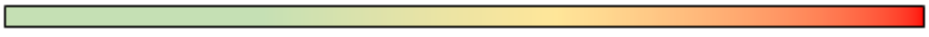
_____

Please rate your Wellness

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

1 Poor  10 Excellent

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

1 Low  10 High

Reasons:

_____

_____

_____

_____