



## CONFIDENTIAL NEW PERSON INFORMATION

### Personal Information

Full name:		Date:	
Address:			
Home phone:	Work phone:	Mobile:	
Email address:			
Best time/place to contact you if required:			
Date of birth:	Age:	Height:	Weight:
Marital status:    M   S   W   D	Spouse/Partner/Guardian name:		
Family Members:			
Occupation:			
Name of Health Fund:			
Interests, Hobbies, Passions:			

How did you hear about our Centre and / or who referred you? \_\_\_\_\_

### Addressing What Brought You Into This Centre

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please turn the page and skip to the "General Health History".

### Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = very severe	When did this episode start?	If you have had this condition before, when?	Did the problem begin with an injury?	% of the time symptoms are present
1.					
2.					
3.					
4.					

**Doctor's notes** \_\_\_\_\_

\_\_\_\_\_

Other doctors you have seen for these conditions:	Name:
<input type="checkbox"/> "Limited Scope" Chiropractic Doctor (focuses mainly on neck and back pain)	
<input type="checkbox"/> "Wellness" Chiropractic Doctor (focuses on health and well being as well as underlying cause of pain and health concerns)	
<input type="checkbox"/> Medical Doctor	
<input type="checkbox"/> Other (please describe)	

## General Health History

### Stressors

Often the accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you. Please list your top three stresses (you have ever had) in each category to further help us to evaluate your current health status:

#### 1. Physical stress (falls, accidents, work postures, sporting trauma, motor accidents, etc.)

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

#### 2. Bio-chemical stress (smoking, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

#### 3. Emotional stress (work, relationships, finances, self-esteem, grief, etc.)

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

## Specific Health History

Have you ever had standing spinal x-rays taken? Yes  No  If Yes: When \_\_\_\_\_ Where \_\_\_\_\_

Do you wear orthotics or heel lifts? Yes  No

Have you ever had any surgery? (Please include all surgery)

\_\_\_\_\_

## Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

\_\_\_\_\_

\_\_\_\_\_

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

\_\_\_\_\_

\_\_\_\_\_

## Past Health History

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

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low blood sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Migraines	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis/Neurogia
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Reflux	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Shingles
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Snoring	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vertigo

Other (please explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Lifestyle Comments

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please rate your:

Eating habits:	Exercise habits:	Sleep:	General health:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help us to better understand you which has not been discussed?

This may include other health or life circumstances that you think may be relevant.

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## OUR PURPOSE

To inspire and support MORE LIFE and BETTER HEALTH for you, your family and our community with quality, professional, relaxed chiropractic wellness care.

**DEFINITIONS** that when fully understood, will help you get the most out of coming to our Centre's.

1. HEALTH measures LIFE, ideally with optimal physical, biochemical, and emotional wellbeing.
2. SUBLUXATION represents LESS LIFE, from progressive spine and nerve system dysfunction.
3. CHIROPRACTIC supports MORE LIFE, and BETTER HEALTH by adjusting and retraining subluxation.

## INFORMED CONSENT

Chiropractic care is well recognized as being extremely safe and effective method of care for many conditions.

Chiropractors complete a 5 year, full time university degree to become a registered practitioner.

However, as with all health care professions, there is a small risk of injury, including although not limited to;

muscle and joint soreness, strains and sprains (to a ligament or disc; in the neck 1 in 139,000 or low back 1 in 62,000), fractures, strokes or stroke like symptoms (1 in 5.85 million neck manipulations) and an exacerbation and/or aggravation of an underlying condition.

This centre is a research based centre. In order to always provide excellent care for the community, statistical data is collected as a result of people attending our centre's. As part of your Chiropractic care, re-examinations are conducted to monitor your health improvements. This information is used for professional research purposes and your anonymity and privacy will be maintained at all times.

I hereby give consent to receive Chiropractic care from a registered Chiropractor and agree to undergo re-examinations if and when required.

Full name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Chiropractors' name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature \_\_\_\_\_

Welcome to Chiropractic, enjoy the journey towards MORE LIFE and BETTER HEALTH.

Please feel free to ask questions at any stage of your care.