

Date:

Pt #:

Welcome to Pure Chiropractic

Thank you for choosing our clinic. You have placed a trust in us that we value very highly.

Personal Details

First names: _____ Surname: _____

Title: Mr / Mrs / Miss / Ms / Other _____ Date of Birth: _____ Age: _____

Address: _____

_____ Postal code: _____

E-mail: _____ Marital status: _____

Telephone: Home: _____ No. of children _____

Work: _____ Ages of children _____

Mobile: _____

Occupation: _____ Hobbies: _____

How were you referred to Pure Chiropractic:

- leaflet yellow pages newspaper signage
 G.P. family/friend free screening other _____

General Health Information

GP Name: _____ Telephone: _____

GP Address: _____

Date of last: Physical Exam: _____ Spinal X-ray: _____

Do you/have you had any major health problems or operations: yes no

If yes, please describe: _____ When: _____

List any medications, vitamins, herbs etc. you are presently taking: _____

Have you ever taken steroid medication for a prolonged period? yes noHave you ever had a stroke or been advised you are at risk? yes noHave your family (parents/siblings) ever had a stroke? yes no

Work Activities

 sitting standing light labour heavy labour

Exercise

 none moderate daily heavy

Habits

 smoking _____ per/day alcohol _____ units/wk water _____ cups/day high stress levels

Health Objectives

 pain relief correction of

underlying problem

 maximise healthHave you ever had the following: Chiropractic Osteopathy Physiotherapy

If so, approximately how many sessions: _____

Your Health Profile

Describe your major complaint: _____

How long have you had this condition: _____

What type of pain is it: (tick more than one if applicable)

- sharp shooting dull ache
 constant intermittent radiating other _____

What caused this condition:

- fall lifting strain stress accident unknown

Since the onset of the problem, is it:

- getting better getting worse about the same

What makes you feel **BETTER**: _____

What makes you feel **WORSE**: _____

Have you had any previous episodes of the condition: yes no

If yes, when: _____

To ensure you receive the best treatment possible, we need to be familiar with your medical history. Please make us aware of any of the following conditions that you may experience or have experienced in the past 12 months:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> loss of taste | <input type="checkbox"/> chest tightness | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> lights bother eyes | <input type="checkbox"/> neck stiffness | <input type="checkbox"/> constipation | <input type="checkbox"/> pins/needles-leg |
| <input type="checkbox"/> ring/buzz in ears | <input type="checkbox"/> neck pain | <input type="checkbox"/> diarrhoea | <input type="checkbox"/> numbness-feet |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> tense shoulders | <input type="checkbox"/> indigestion | <input type="checkbox"/> sleep problems |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> pins/needles-arm | <input type="checkbox"/> heartburn | <input type="checkbox"/> lack of energy |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> numbness-hands | <input type="checkbox"/> ulcers | <input type="checkbox"/> depression |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> menstrual pain | <input type="checkbox"/> hot flushes |
| <input type="checkbox"/> fainting | <input type="checkbox"/> mid back stiffness | <input type="checkbox"/> irregular cycles | <input type="checkbox"/> eczema |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> mid back pain | <input type="checkbox"/> problems urinating | <input type="checkbox"/> allergies |

I consent to a chiropractic examination, scan and relief treatment if necessary.

Signature: _____

Date: _____