CH: TYPE: NP DATE: SCANNED: ☐ X-RAYS: ☐

POSTURE: ☐ CLINIKO: ☐

ROF DATE: _____

# Wellbeing CHIROPRACTIC

PATIENT ID: _____

## PATIENT INFORMATION

Full Name: _____

Date of Birth: / / Occupation: _____

Address: _____

Mobile: _____ Email: _____

Who may we thank for referring you? _____

Or, how did you find out about us?

☐ GP ☐ Passing ☐ Google ☐ Talk

☐ Facebook ☐ YouTube ☐ Other: _____

Previous Chiropractor: _____

Last Chiro Visit Date: / /

Last Full Spine X-ray: / /

Emergency Contact: _____ Emergency Contact Mobile: _____

## HOW CAN WE HELP YOU?

Why are you looking to receive care today? _____

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

How would you describe your symptom/s?

☐ Numb ☐ Cramping ☐ Throbbing

☐ Tingling ☐ Nagging ☐ Stabbing

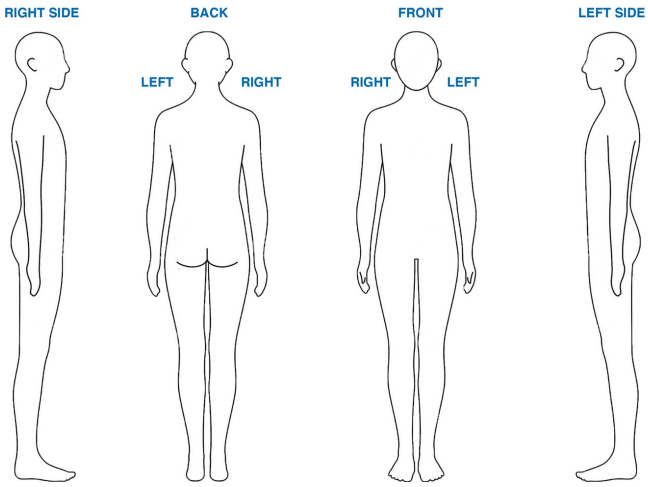
☐ Stiffness ☐ Sharp ☐ Pinching

☐ Dull ☐ Shooting ☐ Swelling

☐ Aching ☐ Burning ☐ Itching

☐ Other: _____

Please indicate area/s you have pain or symptom/s:




## IMPACT OF YOUR SYMPTOMS

How are your symptoms interfering or affecting your life?

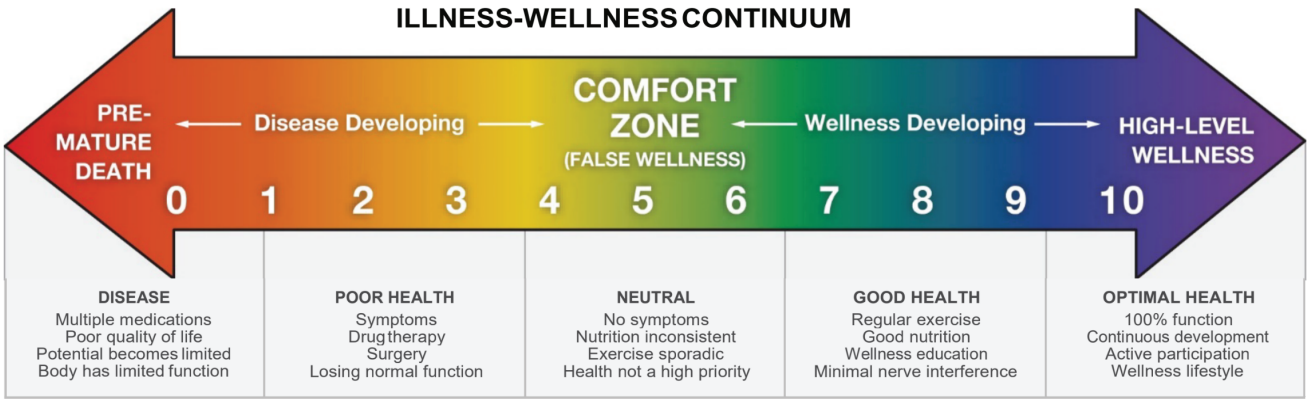
| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Exercise | ☐ | ☐ | ☐ | ☐ | Sitting | ☐ | ☐ | ☐ | ☐ |
| Work | ☐ | ☐ | ☐ | ☐ | Walking | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | Standing | ☐ | ☐ | ☐ | ☐ |
| Leisure | ☐ | ☐ | ☐ | ☐ | Concentration | ☐ | ☐ | ☐ | ☐ |
| Driving | ☐ | ☐ | ☐ | ☐ | Patience | ☐ | ☐ | ☐ | ☐ |
| Self-care | ☐ | ☐ | ☐ | ☐ | Energy | ☐ | ☐ | ☐ | ☐ |

How committed are you to correcting this issue? (Circle)

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

## PATIENT WELLNESS ASSESSMENT




Based on the diagram above; What number do you think your health is **today?**_____

In **12 months** where would you like your health to be? _____ Which **direction** is your health currently heading (1 or 10)? _____

What are your health goals?

Immediate: _____

Short term: _____

Long term: _____

## HEALTH & ILLNESS HISTORY

The nervous system coordinates the body. Symptoms MAY be caused by nervous system dysfunction. Indicate any areas of concern:

| NECK C1-C7 | | MID-BACK T1-T12 | | LOW-BACK L1-L5 | | PELVIS-COCCYX |
|---|---|---|---|---|---|---|
| ☐ Headache | ☐ Tiredness | ☐ Asthma | ☐ Gastritis | ☐ Constipation | ☐ Knee pain | ☐ Stomach pain |
| ☐ Migraine | ☐ Neuralgia | ☐ Hand pain | ☐ Bronchitis | ☐ Colitis | ☐ Bed wetting | ☐ Sitting pain |
| ☐ High BP | ☐ Sinusitis | ☐ Gall bladder | ☐ Shingles | ☐ Hernias | ☐ Impotence | ☐ Haemorrhoids |
| ☐ Dizziness | ☐ Adenoids | ☐ Stomach | ☐ Chest pain | ☐ Appendicitis | ☐ Sciatica | ☐ Pruritis |
| ☐ Vertigo | ☐ Tonsilitis | ☐ Ulcers | ☐ Liver | ☐ Varicose veins | ☐ Ankle pain | ☐ Itching |
| ☐ Insomnia | ☐ Arm pain | ☐ Hives | ☐ Heartburn | ☐ Period pain | ☐ Leg cramps | ☐ Buttock pain |

## TRAUMAS

**Please list any event and how long ago?**

Motor vehicle accidents (driver or passenger): _____

Work or school related accidents or injuries: _____

Sport or exercise related accidents or injuries: _____

Random accidents (falling down stairs/tripping): _____

Accidents as a child or looking after children: _____

Any additional trauma history: _____

## ADDITIONAL HISTORY

Medications: _____

Surgeries: _____

Cancers: _____

Other: _____

Current Health Conditions: _____

Past Health Conditions _____

Your birth (Please circle): Natural / C-Section / Unknown

Are you pregnant? ☐ YES ☐ NO _____ weeks