Tweed Chiropractic Clinic

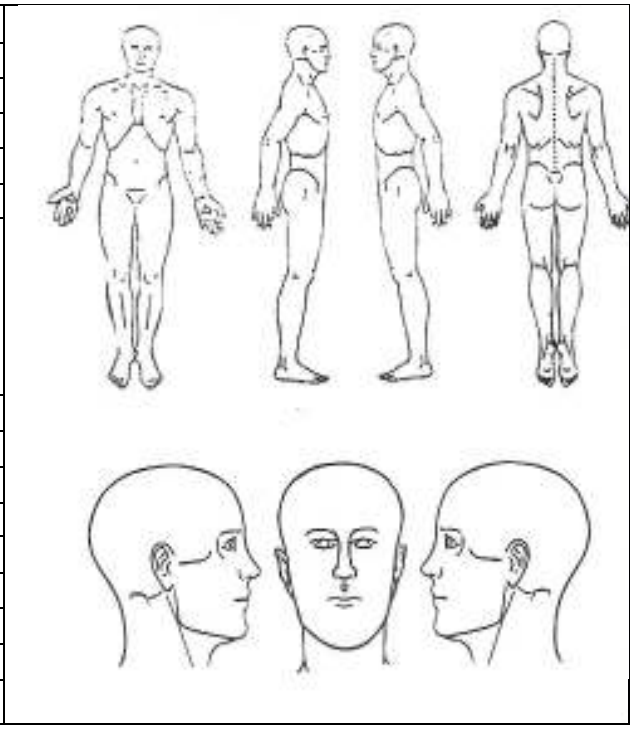
The best of health... Naturally

Name: _____ Age: _____ BIRTH DATE: _____
ADDRESS: _____ POSTCODE: _____
Tel(h) _____ Tel(w) _____ Mobile: _____
Email: _____
Occupation _____ Employer _____
Address _____ Is this a personal injury Yes/No
_____ case?
No of children ___ Ages _____ Your height: _____ Your weight: _____
I have been referred to this office by Dr/Mrs/Mr _____
I found out about this clinic through: Family ☐ Web ☐ Friend: ☐ Bt directory: ☐
Website: ☐ Yellow pages: ☐ Other: ☐
Have you been treated by a chiropractor before? Yes/No Whom? _____
My health insurance is with: _____ Covers chiropractic? Yes/no

I am seeking: Temporary Pain Relief only ☐ Relief and Optimum corrective & rehabilitative care ☐
Enhanced Athletic Performance ☐ Maintenance/ Wellness Care ☐

My primary condition: _____

I have had this problem for (duration): _____ Inherited condition Yes/No
Expanded History: _____



Anything make it better? _____ Worse? _____
Describe Pain Achy Sharp Shooting Constant
Does Pain radiate or refer? Draw an arrow on diagram→
Severity: Please rate your pain: @ best: /10 @ Worst: /10
Timing: Morning Evening After/ During Exercise
General Injuries/Trauma _____

Are you currently taking any supplements, medications?

Drugs	Dose	Reason

Do you play sport/ exercise? Yes/No What? _____
Any past surgeries? Yes/No When? _____ What? _____
What are your goals from this treatment? 1. _____ 2. _____
Goals might include: Less pain at night, Increase my speed when running, Climbing Stairs, Easier breathing, better overall health etc…
Notes: _____

Review of Systems: Have you ever suffered from any of the following past or present?

Past	pres		Past	pres		Past	pres	
		Low Back Pain			Skin disorders			Digestive problems
		Mid Back Pain			Eczema			Diarrhoea
		Neck Pain			Eye function			Abdominal pain
		Headaches			Glasses/contacts			Constipation
		Shoulder pain			Ear function			Piles
		Elbow			Hearing aides			Incontinence
		Wrist			Nose			Bed wetting
		Hand			Throat			Menstrual disorders
		Hip pain			Respiratory disorder			Sexual disorders
		Knee			Shortness of breath			Afternoon tiredness
		Ankle			Asthma			Chronic fatigue
		Foot			Sinus problems			Sleeping problems
		Cramps			Heart disorders			Allergies
		Numbness, tingling			Blood disorders			Hay fever
		Balance			Circulation disorders			Diabetes
		Amputation			Swollen limbs			Loss of smell
		Vertigo			Painful lymph nodes			Insomnia
		Dizziness			Know lymph disorder			False Teeth
		Smoker						Jaw clicking/ Pain

If you ticked any of the above please expand a little: _____

_____

_____

ANYTHING else about your health that you have not mentioned? _____

_____

Please describe the health of your immediate family? _____

How many glasses water do you drink/ day ___ How many cups of tea/coffee do you drink/ day? T C

How much fizzy pop do you drink a day? ___ How much alcohol do you drink per week? _____

For women only:

Might you be pregnant? Yes/No Weeks _____ How many pregnancies? _____

How many live births? _____ Were the births traumatic? Yes/ No

Please explain: Forceps Episiotomy C - section Ventouse/suction Prolonged labour

Other: _____ HRT: _____ Birth Control Pill: _____ Menopause: _____

For men only:

Have you ever had a prostate problem? Yes/No Have you been checked ? Yes/No

Please list the activities of your daily life that are most affected: 1. _____

2. _____ 3. _____ 4. _____

GP: _____ GP's Surgery: _____

Notes: _____

_____

_____

I declare that the information provided is true to the best of my knowledge and I now consent to a physical examination. I may remove this consent later.

Signed: _____ Patient Name: _____ Date: _____