Booval Chiropractic

Today's date: _____

Please print clearly, and be thorough. Thank you! Please note this form has <u>two</u> sides.

First Names: _____ Family Name: _____

Address: _____ Post Code: _____

Age: _____ Date of Birth: _____ Marital Status: _____ Title: _____ No. of Children: _____

Work Tel: _____ Home Tel: _____ Mobile: _____

Occupation: _____ Are you a: ☐ Private patient ☐ EPC/CDM ☐ DVA ☐ W/Cover

Email: _____ Date of last Chiropractic Care: _____

Emergency contact: _____ Emergency number: _____

Do you have private health (with extras cover)? ☐ Yes ☐ No If yes, who with? _____

How did you learn of the Clinic? _____

What kind of Chiropractic Care do you prefer? (please tick)

☐ Relief Care only (this is more likely to be temporary)
☐ Relief and Correction (this tend to improve overall health and to be more permanent)
☐ Preventive/ Wellness Care

Please list the problems for which you seek help today:

1: _____ 3: _____

2: _____ 4: _____

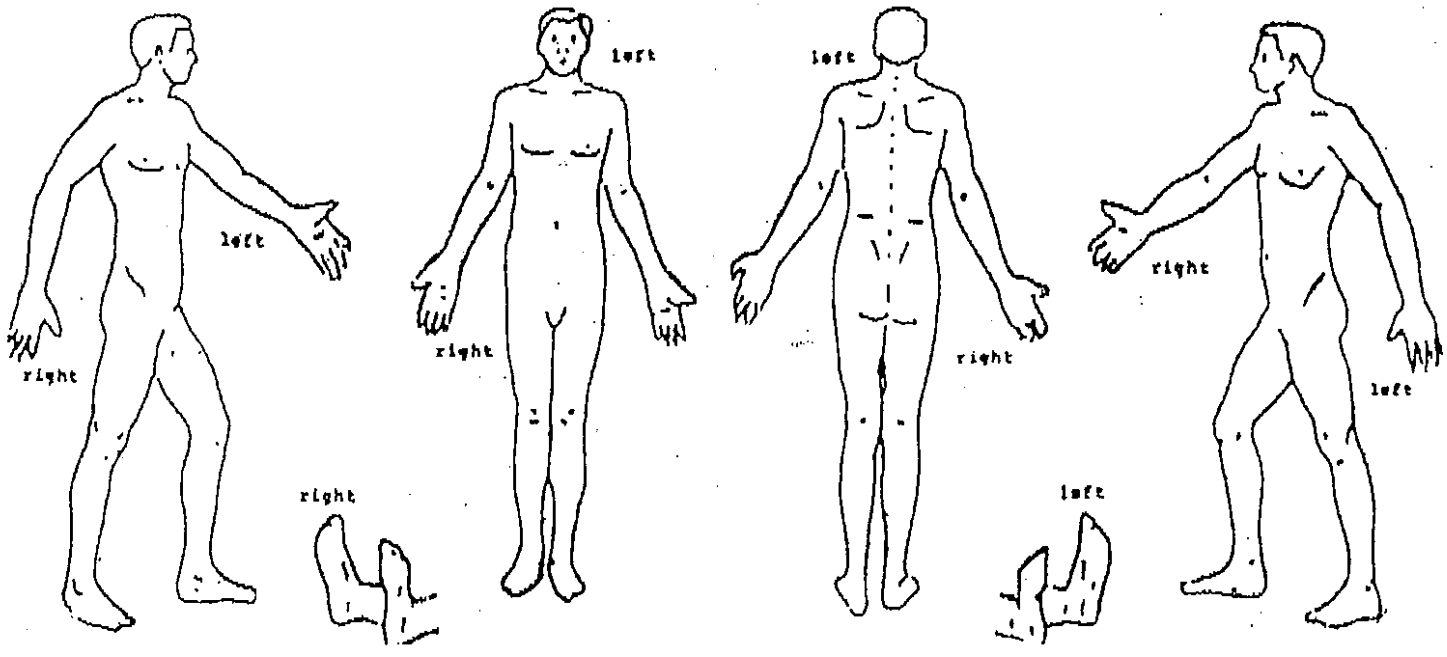
Pain Severity

Please make a SINGLE mark through a line at a point showing how bad the pain is now.

Problem 1: No Pain (_____) Unbearable
Problem 2: No Pain (_____) Unbearable
Problem 3: No Pain (_____) Unbearable
Problem 4: No Pain (_____) Unbearable

Pain Chart

Please <u>shade</u> the pain areas, DO NOT use arrows or circles.



List ALL drugs/medicines you take _____

_____

List ALL operations (dates, too) _____

List ALL x-rays (dates, too) _____

List ALL accidents (dates, too) _____

TICK what you **HAVE NOW**, and **UNDERLINE** what you **HAVE HAD** in the last **FIVE** years.

Alcoholism	Dizziness	Ear ache
Allergy	Diabetes	Sexually transmitted disease
Anxiety/ Depression	Convulsions	Painful sex
Arm Pain	Bowel trouble	Gout
Arthritis	Tinnitus	Ankle swelling
Joints swollen	Digestive difficulties	Menstruation pain
Abdominal pain	Spinal curve	Menses irregular
Knee pain	Scoliosis	Hot flushes
Leg pain	Fever	Breast lumps
Chest pain	Fatigue	Vomiting blood
Elbow pain	Cancer	Thrombosis
Ankle pain	Hoarseness	Low blood pressure
Hip pain	Asthma	High blood pressure
Foot trouble	Difficulties breathing	Stroke
Hand pain	Scarlet fever	Heart disease
Headache	Gall bladder trouble	Drug dependence
Jaw Pain/ Clicking	Urinating frequently	Epilepsy
Low back pain/ Stiffness	Urinating pain	Relationship stress
Mid back pain	Swallowing difficulties	Job stress
Migraine	Kidney trouble	Other stress
Neck pain/ Stiffness	Deafness	Other (please explain)
Shoulder pain	Prostate trouble	

How much do you smoke? _____ What exercise do you get? _____

How much alcohol do you consume weekly? _____ How many alcohol-free days weekly? ____

Do you sleep well? ☐ Yes ☐ No How much coffee/cola do you consume daily? _____

Do you eat a full breakfast daily? ☐ Yes ☐ No Is your diet good (fresh fruit, vegetables etc. daily?) ☐ Yes ☐ No

Is there anything else we should know about you or your health (please explain) _____

_____

_____