CHIROPRACTIC INTAKE & HISTORY

WholeBodyChiro
health by design

CLIENT INFORMATION

Name _____
FIRST NAME LAST NAME

Address _____
Suburb _____ Post code _____

Home Phone _____
Mobile Phone _____
E-mail _____

Sex □ F □ M Age _____ Birthday _____

Date of initial appointment _____

Employer / School _____
Occupation _____
Spouses name (if applicable) _____

IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact number _____

Who may we thank for referring you

_____

HOW CAN I HELP YOU?

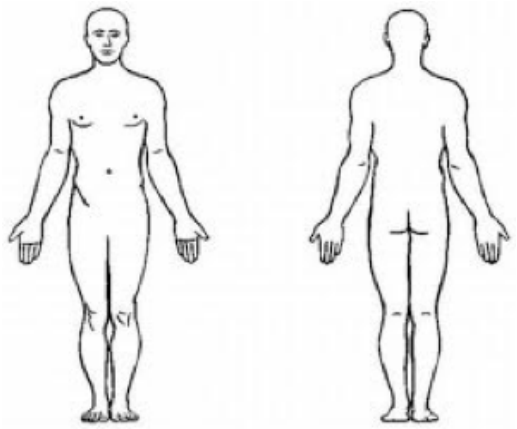
What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

What does it feel like (check where appropriate)?

☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramping
☐ Nagging
☐ Sharp
☐ Shooting
☐ Burning
☐ Throbbing
☐ Stabbing
☐ Swelling
☐ Other _____

Please circle areas of pain/symptoms: ⇨



IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your day-to-day life?

1. _____
2. _____
3. _____

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

1) What is your highest priority for your health in the **next 3 weeks**? _____

_____

2) What would you like to get back to doing once you reach your next level of health and function, say in **3 months**?

_____

_____

3) What level of health would you like to enjoy long-term, say **3 years** from now?

_____

_____

HEALTH & ILLNESS HISTORY

Please check the box beside conditions that you have or have had.

- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back pain
- ☐ Back tension/stiffness
- ☐ Cardiovascular issues
- ☐ Cancer
- ☐ Circulation issues
- ☐ Childhood Illnesses
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diharea/IBS)
- ☐ Elbow/hand/wrist issues
- ☐ Endocrine issues (Thyroid)
- ☐ Foot/Ankle issues
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Neck tension/stiffness
- ☐ Poor balance
- ☐ Poor concentration
- ☐ Reproductive issues
- ☐ Scoliosis
- ☐ Shoulder issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDIOCATIONS & SUPPLEMENTS

Any other information that you would like to share?
(allergies, medications, supplements, injuries or other health concerns)

_____

_____