Welcome to Topsham Chiropractic

PLEASE PRINT THIS FORM AND FILL OUT BEFORE COMING IN

My mission is to educate and adjust as many people as possible through natural chiropractic care. Misalignments of the body and nervous system are called subluxations and prevent the body from functioning optimally. Please fill out this questionnaire as carefully as you can so that we can begin to assess your current level of health.

PERSONAL DETAILS – Please print clearly **Date:** ……

Forename (s): …… Surname: …… Date of Birth: ……

Full Address: …… …….. Age:……
……...Post code……..

Telephone Numbers (Including STD code) Home: …….. Work: ……
Mobile: …… E-Mail……

Please tick if you would not like to receive e-learning emails ☐ Monthly Newsletter by email ☐

Marital Status: ……. Height: …… Weight:……

Number of children: …… Age of children: ……

Occupation: ……..…….. Number of years in current occupation: ……..……..

Who referred or recommended you to us? ……..……
Next of kin?…… Relationship?……contact no……

GP's Name and Address: ……..
……

YOUR CURRENT HEALTH

Do you have health concerns or symptoms? Yes/No
If you are in good health and have come for a chiropractic check up please turn over to the next page

Please circle your main complaint:
Breathing, digestive, eyes / ears, postural change, low immunity, mood disorder, back pain, headache, sports injury.
Other…….……
……

Do your symptoms radiate to other areas?
E.g. Leg(s), arm(s), head,
other…….
……
When did it first start? ……..
Was it sudden or gradual onset? ……..……
How many episodes have you had? ……..

Do the symptoms change with activity/movement or are they constant?…….
……..…….

Was there an accident or cause of this condition?
Please explain: ……
……
……

What makes your symptoms better? ……
What makes your symptoms worse?……
When is it worse? Am, Pm, during sleep, varies
Do your symptoms wake you from sleep Y / N

Have you seen another specialist for this condition?
Specialist……
Treatment……...
Result……..

If you have pain, on a scale of 0-10 in which box would you put your pain?

o at best **X** at worst = If both the same

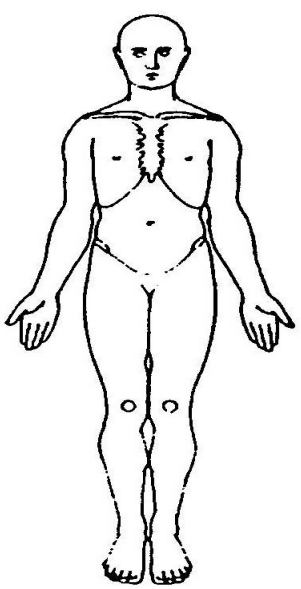
No Pain	1	2	3	4	5	6	7	8	9	10	**Maximum Pain**

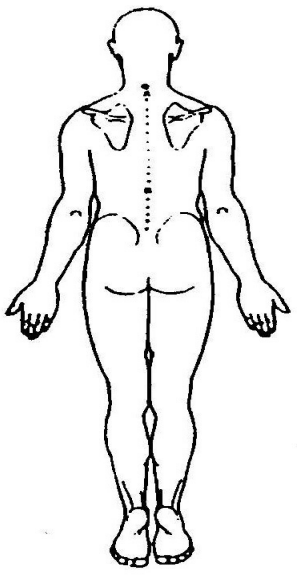
Please draw on the bodies below where your symptoms are and the type of sensation using the Indicated shading

XXX = Burning **OOO** = Tingling

/ / / / = Aching + + + = Stabbing

- - - - = Numbness





GENERAL HEALTH CONDITION

How do you rate your current level of health?
Poor / fair / good / excellent
What are your health goals?……
……
……
Please tick below if you or members of your family have suffered from any of the following conditions:

	You	Family
Headaches/Migraines	❑	❑
Dizziness	❑	❑
Loss of consciousness	❑	❑
Double vision	❑	❑
Tinnitus/ringing ears	❑	❑
Deafness	❑	❑
Eye trouble	❑	❑
Trouble swallowing	❑	❑
Jaw pain	❑	❑
Osteoporosis (brittle bones)	❑	❑
Depression	❑	❑
Breathing problems	❑	❑
Chest pains/heart condition	❑	❑
Abdominal pain	❑	❑
Digestive problems	❑	❑
Bowel/Bladder problems	❑	❑
Difficulty urinating	❑	❑
Sex organ/Menstrual pains	❑	❑
Sudden weight loss/gain	❑	❑
Allergy	❑	❑
Broken bones	❑	❑
General muscular aches	❑	❑
Arthritis	❑	❑
Multiple sclerosis	❑	❑
Diabetes	❑	❑
Cancer	❑	❑
Stroke	❑	❑

WORK AND SOCIAL HISTORY

Any previous road traffic or other accidents?……
……
……
Please circle which daily activities you perform most:
Bending Lifting Sitting Driving
Other ……

What is your current exercise level? Low / moderate / high
Do you consider yourself fit YES / NO

What Leisure / Sport / hobby, activities?
……
……
……

Do you drink alcohol? YES/NO Units/week……..
Do you smoke? YES / NO Per day……..
How many hours do you sleep most nights?……
Do you consider your life stressful? YES / NO

DIET

Are you vegetarian? YES / NO
How many portions of fruit/ veg do you eat per day?
……..
How many days a week do you eat meat?
……..
How many cups of tea / coffee do you drink per day?
……..
How much water do you drink per day?……..
Do you have any food allergies / sensitivities?……
……
……

GENERAL MEDICAL HISTORY

Surgeries / Hospitalisation? ……...
……..
Major illness? ……..
……..
Any Medication / supplements taken at present?…….
……..
Do you have any other symptoms or health problems?
……..
Are you currently seeing any doctor or specialist for any reason?……..
……
Is your present condition suffered by your blood related Family? YES / NO
Are you pregnant? YES / NO

What are your expectations from this consultation?
……..
……..
……..

CONSENT TO EXAMINATION &TREATMENT

The techniques used to examine you may include palpation (using the hands to feel the position and movement of joints), postural assessment, neurological and orthopaedic assessment (reflex and muscle strength testing). Should x-rays, MRI scans or other investigations be required the chiropractor will discuss this with you.

Do you consent to your GP being contacted if required? YES / NO

Please read and sign below

I consent to a chiropractic physical examination today and understand that a report of the findings from this examination will take place on a second visit (ROF visit). I understand that my notes and any x-rays or MRI scans will remain property of the clinic.

Signed:……

Date:……