CompleteHealth
CHIROPRACTIC - PHYSIOTHERAPY - MASSAGE

WELCOME

Patient Information

Name _____ Date of Birth _____

Address _____ Post code _____

Home phone (_____) _____ Work phone (_____) _____ Mobile _____

Occupation _____ Email _____

Status (please tick): Single Married Divorced Widowed Number of children ____ Ages _____

Private Insurance Co. _____ Will you be claiming insurance? (Please tick) Yes No

Reason for consultation: _____

Whom may we thank for referring you to our clinic? _____

Your Health Profile

Why This Form Is Important

As a wellness based chiropractic clinic, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to us, and second, to offer you the opportunity of improved health potential in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the affects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Early Years (to age 16)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years	**Yes**	**No**	**Unsure**
Did you have any serious falls or physical traumas as a child?			
Did you play youth sports?			
Did you have any surgery?			
Any prolonged use of medicines such as antibiotics or an inhaler?			
As a child were you under regular Chiropractic care?			

Comments: _____

_____

Adult (18 to present)	**Yes**	**No**	**Unsure**
Do/did you smoke?			
Do/did you drink alcohol?			
Have you been in any accidents?			
Have you had any surgery?			
Do/did you take any medications/drugs?			
Do/did you play any adult sports?			

On a scale of 1 to 10 describe your stress level: (1 = none, 10 = extreme)

Occupational _____ Personal _____

On a scale of Poor, Good or Excellent, please rate your:

Diet: _____ Exercise: _____ Sleep: _____ General health: _____

On a scale of 0-10 (10 being Excellent), rate your quality of life: _____

Addressing the issues that brought you to this office

If you have no symptoms or complaints and are here for Wellness Services, please tick here ☐ and then please skip to **'Health Profile'**. Otherwise, briefly describe the chief area of complaint.

Chief complaint and cause _____

If you are experiencing pain, is it: ⚫ Sharp ⚫ Dull ⚫ Intermittent (comes & goes) ⚫ Constant

How long have you been experiencing this problem? _____

Since the problem has started, is it: ⚫ About the same ⚫ Getting better ⚫ Getting worse

What makes it worse? _____

Indicate what your present condition is affecting: ⚫ Work ⚫ Sleep ⚫ Walking ⚫ Sitting ⚫ Hobbies ⚫ Leisure

Rate your level of pain (please circle): No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Other Doctors seen for this problem (please list):

Chiropractor: _____ Medical Doctor: _____

Other: _____

Health Profile

Please tick all symptoms you have ever had, even if they do not seem related to you current problem.

⚫ Headaches
⚫ Migraines
⚫ Neck Pain
⚫ Mid back pain
⚫ Low back pain
⚫ Shoulder pain
⚫ Arm/wrist pain

⚫ Hip pain
⚫ Leg pain
⚫ Knee/Ankle pain
⚫ Pins & Needles

⓪Arthritis

⚫ Morning stiffness
⚫ Fatigue
⚫ Dizziness
⚫ Fainting
⚫ Ringing in ears
⚫ Heart trouble
⚫ High blood pressure
⚫ Poor circulation
⚫ Palpitations
⚫ Chest pain
⚫ Liver problems

⚫ Asthma

⚫ Breathing problems
⚫ Blurred vision
⚫ Indigestion
⚫ Constipation
⚫ Kidney problem
⓪Bladder problems
⓪Prostate trouble
⓪Diabetes
⓪Allergies
⓪Hot sweats
⓪Cancer

⓪Sleep problems
⓪Depression
⚫ Panic Attacks
⓪Other: _____

Women Only
⓪Hot Flushes / Night sweats
⓪Heavy menstruation
⓪Painful menstruation
⓪Irregular cycle

For Women Only (we require the following information)
Date of your last period: ……
Is there any possibility of you being pregnant? (Please tick) ⚫ Yes ⚫ No

Family Health Profile

At our clinic we are also interested in the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your

Family: _____ Friends: _____

PLEASE NOTE THAT 24 HOURS NOTICE MUST BE GIVEN OF CANCELLATION OF A SESSION, FAILING WHICH THERE WILL BE A £15 CHARGE PAYABLE.

I consent to be examined & treated at Complete Health and I agree to settle the cost of such treatment on the same day. The statements made on this form are accurate to the best of my recollection

Signed: _____ **Date:** _____