CHIROPRACTIC HEALTHQUARTERS ADULT HEALTH HISTORY FORM- CONFIDENTIAL

This information is considered confidential and will assist us in assessing your current level of health.

Title _____First Name _____Surname_____

Address _____

Suburb _____Post Code _____

Email _____

Phone (mob)_____ (H/W) _____Age _____

Date of Birth____ / ____ / ____ Who can we thank for referring you to Chiro HQ? _____

Occupation _____ Marital Status _____

Partner's Name_____ Kids names and ages _____

Date of last visit to Chiropractor _____ Date of last Chiropractic X-ray s _____

Who else is on your health care team? (eg Naturopath, Personal Trainer, GP etc.) _____

_____

Yours thoughts are critical to our success in helping you

Our holistic approach to healthcare recognises the body's innate ability to self heal. We focus on continuously improving our client's structural integrity, optimising neurological function and empowering a sustainable lifestyle to live the inspired life they deserve.

To that end, a person's structural integrity and lifestyle stresses can adversely affect their nervous system and general health. Many times, when people think they have a 'back', 'neck' or 'shoulder' problem, what they really have is a health problem that has resulted from life's unresolved stresses and traumas to this point.

Please answer the questions on the following pages so we can understand how best to help you.

Your Health Philosophy:

1. On a scale of 0 to 10 (10 being most important) how important is your Health to you? _____
2. a) On a scale of 0 to 10, (10 being optimum) where you think your health is today? _____

   b) On a scale of 0 to 10, where do you think your health could be? _____
3. What things do you think you might need to change to help you reach your goal?

   a) _____

   b) _____

   c) _____

4. How long do you think it might take to get to that number? _____
5. If we could make personalised lifestyle recommendations that would not only address your main concern, but improve your overall health, would you like to hear them? (Please select)

YES ☐ NO ☐

Your Main Areas of Concern:

Primary Problem

Please describe: _____

How long have you been aware of the problem? _____

Do you know what caused it? _____

Secondary Problem (if any)

Please describe: _____

How long have you been aware of the problem?_____

Do you know what caused it? _____

It is important in manual healthcare therapies to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. When the blood vessels are damaged or deteriorating there are several key symptoms that indicate less blood flow is occurring to the head.
Have you recently experienced any of the following: (Please select)

Unsteadiness on your feet or Severe Dizziness YES ☐ NO ☐

Difficulty Talking or Swallowing YES ☐ NO ☐

Unrelenting Nausea or Vomiting YES ☐ NO ☐

Severe Headaches or Neck Pain Unlike Ever Before YES ☐ NO ☐

Ringing in the ears or Recent Visual Changes YES ☐ NO ☐

Likewise, we are concerned that occasionally patients may have severely deteriorating or damaged disc in their lower spine.
Have you recently experienced any of the following: (Please circle)

Loss of bowel or bladder control YES ☐ NO ☐

Loss of leg muscle size or numbness in the legs YES ☐ NO ☐

Difficulty standing up or progressive weakness in the legs YES ☐ NO ☐

Shooting or sharp pain in the low back or legs when coughing or sneezing YES ☐ NO ☐

Any history of bone thinning disease such as osteoporosis,
or long term use of corticosteroids ? YES ☐ NO ☐

Please list ANY health problems or illness you have or in the past experienced (eg; Diabetes, asthma, cancer, high blood pressure, operations, hospitalisations etc.)

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Please list ANY medications you are currently taking

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Please list ANY traumas or accidents you have experienced in your life to date (e.g.; Motor vehicles accidents, broken or fractured bones, falls, being knocked unconscious etc.)

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Any recent unexplained large loss of weight? YES ☐ NO ☐

Do you give permission for us to share your case information with your immediate family? YES ☐ NO ☐

I acknowledge that any physical activity including assessment carries inherent but minimal risk of exacerbating my condition, and with this understanding I consent to undergo a physical Chiropractic examination for the purposes of diagnosing my condition and determining my state of function.

Signed _____ *Date*_____