# CONFIDENTIAL PATIENT INFORMATION

*Welcome to Optimal Health Chiropractic! Please complete all questions and PRINT clearly.* Date: …… / …… / ……

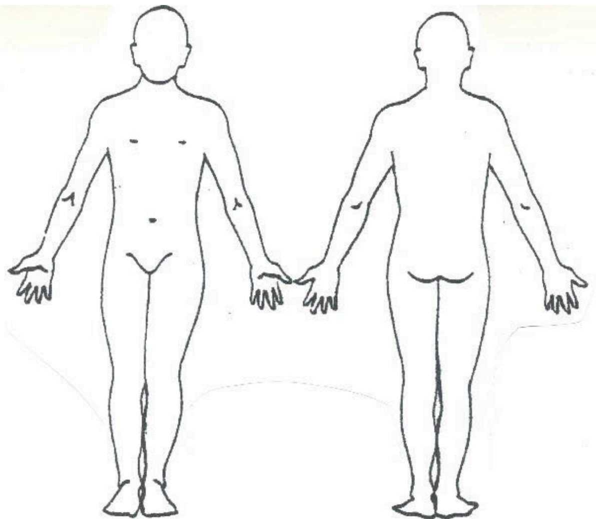
| Surname: | | First Name: |
|---|---|---|
| Address: | | Town: |
| | | Post code: |
| Home Ph: | Work Ph: | Mob Ph: |
| Birth Date: / / | | Email: |
| Occupation: | | Employed by: |
| Type of work: Sitting Computer Standing Driving Lifting Other _____ | | |
| Marital Status: | | Partner's name: |
| Children's names & ages: | | |
| How did you hear about our practice? | | |

Please tick if your reason for attending is to improve Health & Wellness: or

Please list your complaints in order of severity:

1. ____________________ For how long? ____________
2. ____________________ For how long? ____________
3. ____________________ For how long? ____________

*Please mark all problem areas on the diagram below*



FRONT BACK

Is the pain: Sharp Dull / Aching Shooting Burning Throbbing Numb / Tingling

Is the problem getting: Progressively worse Comes & goes Staying the same Progressively better

What aggravates your condition?____________________

____________________

What relieves your condition?____________________

____________________

Have you ever had this pain before? Yes No

If yes, when was the first time?____________________

What do you think is wrong? ____________________

____________________

What do you think caused it? ____________________

Do your father, mother, siblings or children have similar problems? Yes No If yes, who: ____________

Please tick if you have had any of the following:

| | | | |
|---|---|---|---|
| Frequent colds / infections | Poor concentration | Headaches / Migraines | Arthritis |
| Cold hands / feet | Low energy fatigue | Menstrual pain / irregularity | Osteoporosis |
| Digestive problems | Bladder problems | Hot flushes / fevers | Heart disease |
| Anxiety / Nervousness | Irritability | Allergies | Stroke |
| Ulcers | Depression | Mood swings | Diabetes |
| High blood pressure | Low pain threshold | Seizures / fainting | Respiratory problems |
| Low back pain | Neck pain | Dizziness | Cancer |

Please list the doctors who you consulted for these conditions:

1. ______________________________ Diagnosis given: ______________________
2. ______________________________ Diagnosis given: ______________________
3. ______________________________ Diagnosis given: ______________________

Have you ever been to a Chiropractor before? Yes No If yes, when? ______________________

Name and address of current GP:______________________________________________

Date of last physical: ____ / ____ / ____

Please list any operations you have had (and ages):

1. ____________________ 2. ____________________ 3. ____________________

Please list any serious illnesses you have had (and ages):

1. ____________________ 2. ____________________ 3. ____________________

Please list any traumas, accidents, broken bones or injuries you have had (and ages):

1. ____________________ 2. ____________________ 3. ____________________

Are you currently taking medication (including the contraceptive pill)? If yes, what type and what for?

______________________________________________________________________

Do you smoke? Yes No If yes, how many per day? ______________ for how many years?____________

Females Only: Is there any possibility that you are pregnant? Yes No Date of last period: ___ / ___ / ____

Has any blood relative (not including your spouse) had any of the following. If yes, please specify (who, what, when):

Bone or Joint disease (Arthritis / Osteoporosis) ______________________________________

Vascular disease (Heart disease / Stroke / Blood Pressure) ______________________________

Cancer (Benign / Malignant) ______________________________________________

Respiratory problems (Lung / Chest / Asthma) ______________________________________

Digestive problems (Stomach / Bowel) ______________________________________

Reproductive problems ______________________________________________

Diabetes / Metabolic disorders ______________________________________________

Epilepsy / Nervous system disorders ______________________________________

Skin disorders ______________________________________________

Allergies ______________________________________________

Other ______________________________________________

**DECLARATION: This information is accurate to the best of my knowledge.**

PATIENT SIGNATURE:………………………………………………….... DATE: …… / …… / ……

CHIROPRACTOR SIGNATURE:………………………………………………….... DATE: …… / …… / ……

# YOUR HEALTH GOALS

**Name:**.................................................. **Date:** ...... / ...... / ......

The purpose of this questionnaire is to enable your Chiropractor to know what your health objectives are, what your expectations are and what is important to YOU.

**(Please circle your answer)**

Are you happy with the way you look and feel? YES NO

How long has it been since you have felt your best? Years Months Weeks

How long have you been thinking about pursuing your health goals? Years Months Weeks

What are you most interested in improving?
- Overall health
- Less Pains/Symptoms
- Reducing Stress
- Increasing your Energy and Vitality

How long do you think it will take to achieve your health goals? Years Months Weeks

Please list your desired health goals and the areas you are most interested in improving:

____________________________________________________________

____________________________________________________________

____________________________________________________________

Do you understand how chiropractic can help improve your overall health and well-being? YES NO

Thank you