Patient Details & History Form

Full name: ____________________

Preferred Name:____________________ **Date of birth:**____________________ **Age:** ____________

Occupation:____________________ **Hobbies**:____________________

Address: ____________________

Phone: H)____________________ **M)**____________________ **W)**____________________

Email: ____________________

Emergency contact: ____________ **Relationship to you**: ____________ **Phone:**____________

Health Care History

Have you seen a chiropractor before? Yes / No

Have you been, or are you currently under the care of another health care practitioner (i.e. Chiropractor (other), Naturopath, Physiotherapist, Osteopath, Acupuncturist etc.)**?**

Name:____________________ **Type:**____________________ **Date of last visit:**____________

Reason: ____________________

Currently still under care? Yes / No **Did / Is it help(ing)?** Yes / No

How did you hear about Outspoken Chiropractic?

☐ Referral:____________________ ☐ Advertisement:____________________ ☐ Internet

☐ Other:____________________

What is the reason for coming in to see us at Outspoken Chiropractic? *(i.e. increased wellness, increased functioning, optimize health, reduce discomfort etc.)***?**

____

____

____

On a scale of 0-100% where do you rate your current state of health? *(Indicate by circling)*

0 10 20 30 40 50 60 70 80 90 100

Have your health concern(s) / problem(s) affected your life? Your family's life? Yes / No

Has it stopped you from doing anything (i.e. enjoyable activities, hobbies, daily activities etc..)? Yes / No

____

On a scale of 1-10, how committed are you to correcting this issue / advancing your current state of health?

0 1 2 3 4 5 6 7 8 9 10

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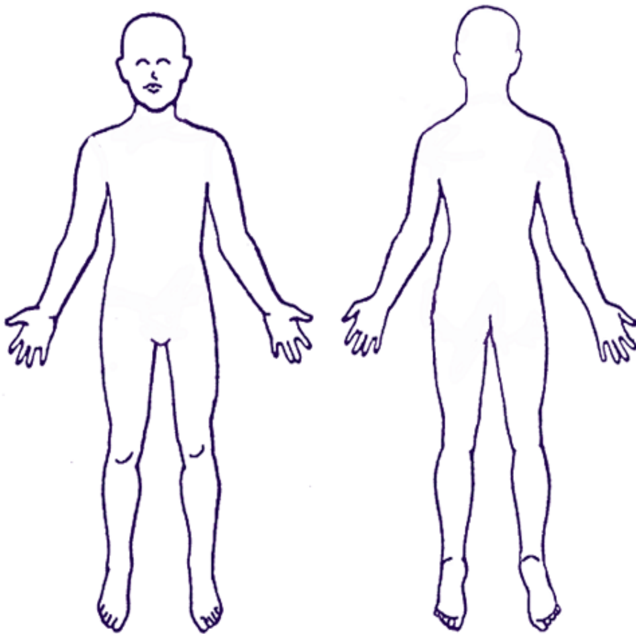
outspoken CHIROPRACTIC

If you experience pain **(P)**, numbness **(N)** or tingling **(T)**,

please indicate on the picture below:



Current medications & supplements

Please list ALL medications (prescription/non-prescription), herbal remedies & supplements you are currently taking

____

____

____

Health History

Have you had any recent/past injuries, falls or accidents which you feel you have not recovered 100% from?

____

____

____

Please tick any of the following if they apply to you and give details:

- ☐ I am pregnant (no. weeks______________)
- ☐ I have been in a serious accident
- ☐ I have had x-rays in the last 5 years
- ☐ I have had surgery and/or been hospitalised
- ☐ I have had a serious illness and/or major health concerns
- ☐ Family history of a particular illness or disease (i.e. stroke, cancer, heart problems, diabetes etc.)

Are there any other health concerns you wish to disclose?

____

STRESS

Are you currently experiencing any stress relating to: (circle)

Occupation   Family   Financial   Study   Sleep   Relationship

Please explain ____

____

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REST

How many hours of sleep do you currently get each night? __________ Is it good quality sleep? Y / N

When you wake up do you feel: full of energy or sluggish and tired

Do you get tired throughout the day? Y / N please specify the time ________________________

What do you usually do to wake yourself up? (coffee, water, food, nap, walk etc) ________________________

EXERCISE

Do you currently participate in any of the following: (circle)

Cardio exercise Resistance training Sport Yoga Dance Other:____________________

Please specify activity and how many times per week you participate in these?

____

Posture Analysis

Height: _____________ (cm) Weight: ___________(Kg)

Nutrition

How many meals do you have per day? ________ **How much water do you drink per day on average?** _______

Do you drink filtered/bottled water? ☐ **Y** ☐ **N** **What % of your diet is organic?** _________%

What % of your diet are packaged foods i.e. ready meals, biscuits, cereals, muesli bars etc..)? ________%

How do you rate your current diet (1 [bad] – 10 [best])? ______ **Do you drink fizzy drinks?** ☐ **Y** ☐ **N**

Do you smoke? ☐ **Y** ☐ **N** **On average how many per day/week?** ____________________

Do you eat fast food ☐ **Y** ☐ **N** **On average how often per week?** ________________________

Do you drink caffeine ☐ **Y** ☐ **N** **How many per day?** ___________________________________

Do you drink alcohol ☐ **Y** ☐ **N** **On average how often per week?** ________________________

What are your short / long term health goals *(i.e. increase function, run a marathon, ↑/↓ weight)?*

Short: ____

Long: ____

Is it important for you to resolve your health concerns as quickly as possible? Yes / No

Consent for Care:

I have reviewed and certify that all the information that I have reported above is correct to the best of my knowledge. I give my consent to continue with the physical examination and commence care at Outspoken Chiropractic.

Signature ____ **Date** ___________________________