Scanned

Chiropractic Balance: Patient History Form

Paremata-Mana @ 10/99 Mana Esplanade (04) 233 8705
www.chirobalance.co.nz info@chirobalance.co.nz

Personal Information

Name		**Today's Date**
Address		
Preferred Phone	**Alternative Ph**	**Date of Birth**
Email		**Male / Female** (Pregnant Y / N)
Emergency Contact (& phone)		
GP Name	**Hrs worked/study per week**	**Height (approx.)**
Occupation	**Employer/School**	**Weight (approx.)**
Who or what referred you to Chiro Balance?		

Current Health

Primary reason for consulting our centre

Rate of Severity (mild) 1 2 3 4 5 6 7 8 9 10 (severe) **How long has this been going on?**

How did it begin (gradual or traced to an event)

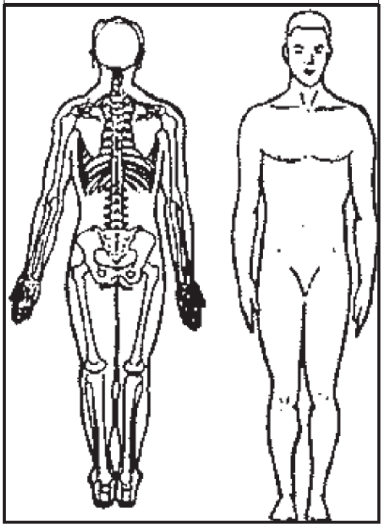
What aggravates it?

What improves it?

What are 3 things you would like to improve your ability to do?

Others seen for this condition

PLEASE MARK AFFECTED AREAS



Main area of Body Pain/Discomfort/Concern

Please circle all appropriate descriptions

Sharp Dull Numb Burning Ache Stiffness

Improving Worsening Same Constant Intermittent

Does the problem radiate anywhere

Other problems you are concerned with

Previous Chiropractic Care (Who/When)

General Lifestyle

Hours per day spent: Sitting/driving ____ Standing ____ Physical Labour ____ Sleeping ____ Other(describe)

Sleeping Position Front / Side / Back **Do you use:** Foot Orthotics / Back Support / Orthodontic device (braces/plate)

Exercise Days per week ____ Describe Activities:

Stretching Days per week ____ **Are you your ideal weight** Y / N (if No, what would Ideal be _____)

Water (per day) less 1L / 1L / more 1L **Caffeinated Drinks** (per day) ____ **Alcohol** (per week) ____ **Smoke/Vape** (per day) ____

What do you eat for Breakfast? **Particular Dietary/ Intolerances?**

Current Medications/Supplements:

Current or Past Mental or Emotional Issues:

Lifestyle Review: Please circle, 10=Poor 1=Ideal

Posture & Standing	10	9	8	7	6	5	4	3	2	1
	Poor posture &/OR uncomfortable standing									Ideal posture with ease & can stand for long time
Sitting	10	9	8	7	6	5	4	3	2	1
	Slouch &/or pain No breaks									Ergonomic set up & take regular breaks or standing desk 20%+
Sleeping Position	10	9	8	7	6	5	4	3	2	1
	Sleep on stomach straight)									Side or Back (spine
Sleeping Quality	10	9	8	7	6	5	4	3	2	1
	Pain &/OR difficult to get to sleep/ stay asleep									No pain & fall asleep easily & stay asleep
Lifting	10	9	8	7	6	5	4	3	2	1
	Pain with lifting OR no technique									Lift with ease & bend knees, move feet, keep head over body
Driving/Passenger	10	9	8	7	6	5	4	3	2	1
	Pain									Comfortable
Physical Work	10	9	8	7	6	5	4	3	2	1
	Can't do it at all									Do with ease
Stretching & Flexibility	10	9	8	7	6	5	4	3	2	1
	Painful, very stiff &/or never stretch									Flexible spine/legs/arms & daily stretch 5min+
Cardiovascular/ Sports	10	9	8	7	6	5	4	3	2	1
	Never do any &/OR causes pain									30min+ (3x week+) & exercise/play sport with ease
Strength Work	10	9	8	7	6	5	4	3	2	1
	Never do any &/OR feel weak									Strength work 5min+ (3x week) & have strong arms/legs/back/core

Movement/ Daily Steps	10	9	8	7	6	5	4	3	2	1
	Minimal daily movement									10,000 steps (90min walk)
Overall level of energy	10	9	8	7	6	5	4	3	2	1
	Wake exhausted &/OR tire as day progresses									Wake up with energy & excellent energy all day
Work (or equivalent) Stress & Busyness	10	9	8	7	6	5	4	3	2	1
	Constantly high &/OR recent significant event of stress									Low stress & stable
Personal Life Stress & Busyness	10	9	8	7	6	5	4	3	2	1
	Constantly high &/OR recent significant event of stress									Low stress & stable
Overall ability to cope with life	10	9	8	7	6	5	4	3	2	1
	Anxious &/OR overwhelmed									Relaxed & cope well
Pause during day	10	9	8	7	6	5	4	3	2	1
	Never pause & always focused past/future									Daily mindfulness 5min+ to relax, connect nature, creativity
Overall Eating Habits	10	9	8	7	6	5	4	3	2	1
	Never think about &/OR low nature based foods									Choose food consciously & majority nature based diet
Water	10	9	8	7	6	5	4	3	2	1
	No water									2L+ filtered water/ day
Caffeine/ Stimulant drinks	10	9	8	7	6	5	4	3	2	1
	6+ day									0-1/ day
Bowel Movements	10	9	8	7	6	5	4	3	2	1
	Less than 3 per week &/OR strain to pass &/OR inconsistent									1-3 per day & pass easily/quickly

Lifestyle Review Total _____ *(please add up)*

220 - ____ (total above)/200 x100 = **_____%**

Past History: Please give date & brief description

Automobile accidents (15km/hr or more) **& Date**

Injuries / falls / fractures / head trauma

Surgery / Operations / Hospital visits / Major Illnesses

Previous Imaging (X-ray, MRI, CT etc)

Family History

General Health History

Please circle **C** if you are currently experiencing or **P** have these symptoms previously:

P	C		P	C		P	C		P	C	
P	C	Headaches	P	C	Hand/Finger Problems	P	C	Cold sores	P	C	Painful periods
P	C	Spacey	P	C	Heart Disease /Condition	P	C	Low energy	P	C	Premenstrual Syndrome
P	C	Dizziness	P	C	High Blood Pressure	P	C	Nightmares	P	C	Menopause Symptoms
P	C	Memory trouble	P	C	Low Blood Pressure	P	C	Burning feet	P	C	Bedwetting
P	C	Ear Aches	P	C	Fainting Sensation	P	C	Overwhelmed by stress	P	C	Foot/ Toe Problems
P	C	Tinnitus	P	C	Rapid Heart Beat	P	C	Decreased urine output	P	C	Reproductive Disorder
P	C	Vertigo	P	C	Heart Palpitations	P	C	Increased urine output	P	C	Depression
P	C	Nose Bleeds	P	C	Chest pain / tightness	P	C	Swollen ankles	P	C	Migraines
P	C	Sinus trouble	P	C	Asthma	P	C	Puffy Eyelids	P	C	Dyslexia
P	C	Snoring	P	C	Chronic cough	P	C	Kidney/ Bladder Infection	P	C	Epilepsy / Seizures
P	C	Itchy/achy eyes	P	C	Wheezing / Pneumonia	P	C	Bad Breath	P	C	Compulsive disorders
P	C	Allergies	P	C	Gall Bladder Issues	P	C	Flatulence	P	C	Sensitivity to light
P	C	Food Sensitivities	P	C	Bloating after meals	P	C	Dark circles under eyes	P	C	ADD/ ADHD
P	C	Eczema	P	C	Trouble with fatty foods	P	C	Irritable bowel or Crohns	P	C	HIV / AIDS
P	C	Excessive Fatigue	P	C	Heartburn/Indigestion/Reflux	P	C	Abdominal cramps	P	C	Autoimmune disorder
P	C	Anxiety	P	C	Stomach Ulcers	P	C	Constipation	P	C	Cancer
P	C	Shortness of Breath	P	C	Anaemia	P	C	Diarrhoea	P	C	Tremors
P	C	Overactive Thyroid	P	C	Crave sweets	P	C	Coated Tongue	P	C	Stroke
P	C	Nervousness	P	C	Diabetes	P	C	Hemorrhoids			
P	C	Excessive Sweating	P	C	Emotional Instability	P	C	Varicose Veins	Any other condition?		
P	C	Underactive Thyroid	P	C	Frequent Colds / Flu	P	C	Prostate problems	_____		
P	C	Always feeling cold	P	C	Immune deficiency	P	C	Impotence			

I have filled in this form to the best of my knowledge. I understand that no accounts are held at Chiropractic Balance & the fee for service rendered is due at time of service. For ACC clients: I understand that if my claim is not accepted that I am liable for the outstanding charges. I consent to the use & disclosure of my personal information by Chiropractic Balance to other health professionals who are involved in my health care.

I hereby give consent to undergo a new patient consultation, examination & adjustment (if indicated)

Sign _____ Print Name _____ Date_____