

- THRIVE CHIROPRACTIC -

All records remain confidential in accordance with privacy requirements

Name: _____ Occupation: _____ D.O.B.: _____

Address: _____

Handedness: Left / Right Phone numbers: work: _____ home: _____ mobile: _____

Spouse/Partner's name: _____ Children (age+names): _____

Email: _____ Have you had chiropractic care before? Yes / No (if yes, when + where?)

How did you hear about us? _____

What has brought you into our office us today? _____

Please mark areas of concern

How long have you had this complaint? _____

Is it getting worse / better / same Have you had this complaint before? Yes / No

Is it worse at: am / pm Does it wake you up at night? Yes / No

Is the symptoms: constant / intermittent / now and then

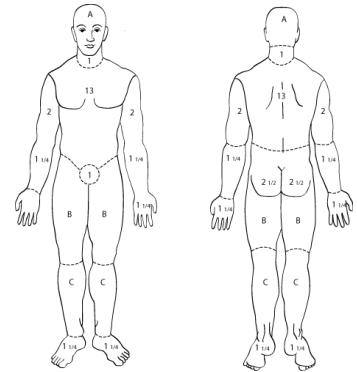
What makes it worse? _____ What makes it better? _____

Previous episodes and treatments? _____ Outcome of those? + or -

Where do you think this is coming from? _____

How does it affect you in your daily life? _____

Other areas of concern? _____ Xrays takes in the last 2 years? Yes / No



List any operations, accidents, fractures, injuries (esp. head and back), car accidents and illnesses you had in the past

What do you do for exercise and how many times per week?

Hours of sleep/night: _____ Number of bowel mvt./day: _____ Water intake per day in litres: _____ Alcohol intake/day: _____

Do you smoke Y / N Have you ever smoked? Y / N Do you take recreational drugs? Yes / No Are you vegetarian? Yes / No

What supplements do you take? _____

What medications do you take? _____

Do you have any allergies? Yes / No (if yes, which ones?) _____

How healthy are you out of 10 (10 = perfect health): 1 2 3 4 5 6 7 8 9 10

How would you rate your diet (10 = extremely healthy): 1 2 3 4 5 6 7 8 9 10

How would you rate your current stress level: (10 = extreme stress): 1 2 3 4 5 6 7 8 9 10

Please circle if you currently have or have had any of the following conditions:

- | | | | | |
|-------------------------|--------------------------|-------------------------|-------------------------------|--------------------|
| Shortness of breath | Heart problems | Blood pressure problems | Pins & needles in legs/arms | Chest pain |
| Depression | Recent weight changes | HIV + | Sinus problems | Cancer |
| Back pain | Regular colds & flus | Bronchitis/pneumonia | Cold feet / hands | Asthma |
| Neck pain / stiffness | Headaches / Migraines | Infections / Anaemia | Jaw/teeth problems / clicking | Epilepsy |
| Dizziness/Vertigo | Incontinence | Eczema | Poor awakening | Diabetes |
| Problems tasting | Problems smelling | Problems with balance | Frequent nose bleeding | Eye problems |
| Ear problems/buzzing | Kidney / liver problems | Loss of memory | Difficulties swallowing | Groin pain |
| Fainting | Diarrhea / constipation | Low energy/Fatigue | Fever | Birth difficulties |
| Muscle cramps | Irritability/Nervousness | Thyroid problems | Glandular fever | Nausea |
| Muscle weakness or pain | Breathing problems | Bladder problems | Sleeping difficulties | Stomach upset |
| Attention difficulties | Swollen joints | Painful intercourse | Pain in testicles | Prostate trouble |
| Premature ejaculation | Painful menstruation | Menopausal symptoms | Altered sex drive | Irregular periods |

Is there anything else we have not mentioned in regards to your health we should be aware of? _____

Your Signature _____

Today's date: _____