# Welcome to Vitality!

*Our team vision is to help people get well and stay well.*

**Please take some time to complete all questions as thoroughly as possible so our team can assess how we can best help you.**

## PERSONAL INFORMATION

| | |
|---|---|
| **Full name:** | **Date:** |
| **Address:** | |
| **Home Telephone:** | **Work Phone:** |
| **Mobile Telephone:** | **Email Address:** |
| **Best Time/Place to Contact You:** | |
| **Date of Birth:** | **Age:** |
| **No. of Children:** **Pregnant? Yes** ☐ **No** ☐ * If you are pregnant, please ask for our pregnancy paperwork | |
| **Marital Status: M S W D O** | **Spouse/Guardian Name:** |
| **Occupation:** | |
| **Hobbies/Interests/Sports:** | |

Have you received chiropractic care before? If so, from whom and when?

_____

Were X-Rays taken? If so, when?

_____

Who may we thank for referring you?

_____

## ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE

*Many people consult our practice for wellness. If you have no symptoms or complaints and are here for chiropractic wellness services, please skip to the **"General Health History"**.*

### Health Concerns

| Please list your health concerns according to their severity. | Rate of severity 1 = mild 10 = worst imaginable | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | % oftime pain is present. |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

Are these conditions interfering with any of the following:

☐ Work/financial capacity ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Relationship/family ☐ Hobbies/Interests ☐ Other

Please explain:_____

_____

What aggravates you problem/s?:

_____

What relieves your problem/s?

_____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? [i.e. Eat better, less alcohol or drugs, meditate or breathe more, less contact sports, activities, etc]. If yes, what?

_____

Have you seen any other health care providers for this condition? ☐ No ☐ Yes. If yes, please provide details

## GENERAL HEALTH HISTORY

*Often times, accumulation of life's three main stressors can lead to health problems and influence our ability to heal. Please pay close attention to this section, as it will help us help you!*

### First Main Stressor - Physical Stressors

Have you had any surgery? [Please include all surgery]

| | |
|---|---|
| 1. Type: | When? |
| 2. Type: | When? |
| 3. Type: | When? |

Have you had any accidents and/or injuries during your lifetime?: e.g car, bike motorbike, work-related, or other [especially those related to your present problems]? Please include any broken bones/dislocations

| | | |
|---|---|---|
| 1. Type: | When? | Hospitalised? Yes ☐ No ☐ |
| 2. Type: | When? | Hospitalised? Yes ☐ No ☐ |
| 3. Type: | When? | Hospitalised? Yes ☐ No ☐ |

Please tick the appropriate answer for each of the following questions:

| | **Daily/almost daily** | **Yes, occasionally** | **Not at all** |
|---|---|---|---|
| Do you exercise? | | | |
| Do you play contact sports? | | | |
| Do you sit for long periods of time? | | | |
| Do you regularly bend and lift? | | | |
| Do you spend more than 2 hours per day using a computer? | | | |

Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Yes ☐ No ☐

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? Yes ☐ No ☐

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor – 1 2 3 4 5 6 7 8 9 10 - Excellent

### Second Main Stressor - Bio-Chemical Stressors

### Diet

Please tick the dietary selection that is appropriate for you for each of the following:

| | **Daily** | **Weekly** | **Monthly** | **Do not consume** |
|---|---|---|---|---|
| Alcohol | | | | |
| Fruit | | | | |
| Fish | | | | |
| Dairy | | | | |
| Eggs | | | | |
| Coffee/Tea | | | | |
| Soft/Energy Drinks | | | | |
| Refined Sugars | | | | |
| Skip Meals | | | | |
| Red meat | | | | |
| Fried Foods | | | | |
| Vegetables | | | | |
| Artificial Sweetener | | | | |
| Organic Foods | | | | |
| Fish/ Seafood | | | | |
| Tobacco | | | | |
| Diet Food | | | | |
| Whole Grains | | | | |
| Poultry | | | | |

Personal satisfaction with diet [please tick]:

| | | | |
|---|---|---|---|
| ☐ Highly Satisfied | ☐ Satisfied | ☐ Unsatisfied | ☐ Highly Unsatisfied |

## Current Medicines and Supplements

Please list any medications/drugs [prescription and non-prescription] you have taken in the past 6 months and why: (e.g. panadol, antibiotics.)_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you currently take._____

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Are you exposed to pollutants, strong smells or aerosols? ☐ Yes ☐ No ☐ Occasionally

Do you use natural/environmentally friendly products at home? i.e. cleaning products or personal care items? ☐ Yes ☐ No

## Third Main Stressor - Mental/Emotional Stressors

Have any of the following occurred recently:

| | | | |
|---|---|---|---|
| ☐ Depression | ☐ Divorce | ☐ Drugs/Alcohol Increase | ☐ Anxiety |
| ☐ Death | ☐ Change in Job Status | ☐ Sleep Disturbances | ☐ Family Problems |
| ☐ Increased Work Stress | ☐ Chronic Fatigue | ☐ Economic Stress | ☐ Other |

Please comment if appropriate: _____

Do you regularly practice some form of meditation, breath work, other mind-body movement or have a routine/strategy to deal with stress? ☐ No ☐ Yes. Explain_____

## HEALTH HISTORY

Please mark in the boxes below if you have experienced any of the following;

| | | | | | |
|---|---|---|---|---|---|
| **Neck pain** ☐ Currently ☐ In past | **Stiff Neck** ☐ Currently ☐ In past | **Headaches** ☐ Currently ☐ In past | **Shoulder Pain** ☐ Currently ☐ In past | **Pain in Mid-spine** ☐ Currently ☐ In past | **Low back pain** ☐ Currently ☐ In past |
| **Allergies** ☐ Currently ☐ In past | **Asthma** ☐ Currently ☐ In past | **Balance Loss** ☐ Currently ☐ In past | **Bloody nose** ☐ Currently ☐ In past | **Breathing problems** ☐ Currently ☐ In past | **Chest Pain** ☐ Currently ☐ In past |
| **Constipation or Diarrhea** ☐ Currently ☐ In past | **Cold/flu** ☐ Currently ☐ In past | **Cold Feet/Hands** ☐ Currently ☐ In past | **Depression** ☐ Currently ☐ In past | **Dizziness** ☐ Currently ☐ In past | **Ears Ring** ☐ Currently ☐ In past |
| **Ear/throat Infections** ☐ Currently ☐ In past | **Fainting** ☐ Currently ☐ In past | **Fatigue** ☐ Currently ☐ In past | **Fertility Challenges** ☐ Currently ☐ In past | **Loss of Memory** ☐ Currently ☐ In past | **Loss of Smell/Taste** ☐ Currently ☐ In past |
| **Light Bothers Eyes** ☐ Currently ☐ In past | **Loss of hearing** ☐ Currently ☐ In past | **Numbness in Fingers/Toes** ☐ Currently ☐ In past | **Nervousness** ☐ Currently ☐ In past | **Pins and Needles in Arms/ Legs** ☐ Currently ☐ In past | **Stomach/Digestive Problems** ☐ Currently ☐ In past |
| **Shortness of Breath** ☐ Currently ☐ In past | **Sleeping Problems** ☐ Currently ☐ In past | **Sinus problems** ☐ Currently ☐ In past | **Stop/Start Urination** ☐ Currently ☐ In past | **Tension & Irritability** ☐ Currently ☐ In past | **Weight Problems** ☐ Currently ☐ In past |
| **Irregular Cycles** ☐ Currently ☐ In past | **IVF program** ☐ Currently ☐ In past | **Lumps in breasts** ☐ Currently ☐ In past | **Menstrual Pain** ☐ Currently ☐ In past | **Menopausal Symptoms** ☐ Currently ☐ In past | **Other** ☐ Currently ☐ In past |

Other [please explain]_____

## FAMILY HEALTH HISTORY

Please note any health issues that are present with family members such as parents, siblings & grandparents

| | | | | | |
|---|---|---|---|---|---|
| ☐ Cancer | ☐ Diabetes | ☐ Hypertension | ☐ Heart Disease | ☐ Arthritis | ☐ Other |

Comment (if relevant)_____

## HEALTH STATUS

Using the scale below, with 10 being excellent, please circle what you believe to be your current state of health.

0 1 2 3 4 5 6 7 8 9 10

Very Poor Poor Average Good Excellent

## HEALTH GOALS

Which of these health goals are the most important to you? Please pick up to 5 and number them from 1 [most important] to 5 [least important]:

| |
|---|
| ☐ **Energy Level and Fatigue** – Do you feel energetic or are you tired of being tired? |
| ☐ **Quality of Sleep** – Do you have difficulty falling or staying asleep? |
| ☐ **Memory and Ability to Focus** |
| ☐ **Digestion** – Do you have problems with reflux, heartburn, bloating, etc.? |
| ☐ **Nutrition** – How healthy is your diet? |
| ☐ **Mood** – Are you happy, anxious, sad, or depressed? |
| ☐ **Stress Levels** – How well are you handling the stresses in your life? |
| ☐ **Allergies and Immune System** – Do you take allergy medication? Are you often sick? |
| ☐ **Understanding more about health and how you and your family can stay healthy**. |
| ☐ **Pain Control/Relief** |
| ☐ **Health Reliability/Stability**- Ability to actively participate in all family/life activities that you need to/want to. |

Are there any other health goals or conditions you'd like to work on?

_____

In what ways do you feel that your life is restricted?

_____

What is the best thing that will be added to your life when you regain your health?

_____

# CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully:

1. I acknowledge that I have discussed with the chiropractor the rare risks associated with my proposed care which include but are not limited to; muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I have had the opportunity to discuss the proposed care with the chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

4. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

5. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics e.g. between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics e.g. less than 1 in 139,000) and the low back (current statistics 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."

…… …… ……. …….

Patient's Signature | Patient's Name (printed) | Date: | Chiropractors signature