WELCOME TO ALIGN CHIROPRACTIC & WELLNESS

Name: _____ Date of birth: _____ Age:_____

Address: _____ Suburb: _____ Postcode: _____

Email: _____

Telephone: H: _____ W: _____ M: _____

Preferred way of contact: **Email** ☐ **Phone** ☐

Name of G.P: Who can we thank for recommending us to you?

Occupation: _____ Marital Status: _____ No. of children? _____

Have you ever had Chiropractic care before? Yes/No If yes, who & when?_____

How can we help you today? _____

_____

Do you have any other health concerns or known illnesses? Yes | No If yes,what? _____

_____

In general, would you say your health is:

1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

In general, how would you rate your energy levels:

1	2	3	4	5
Very High	High	Average	Low	Very low

Please list any accidents or injuries that you have suffered, even those that you consider minor.

_____

_____

Do you play any sports? Yes | No If yes, what? _____

Do you suffer from repeated strains and/or sprains? Yes | No

How often do you exercise for more than 30 minutes per day?

Everyday | 5-6 days/wk | 3-4 days/wk | 1-2 days/wk | 0 days/wk

In general, how would you rate your diet?

1	2	3	4	5
Very healthy	Healthy	Moderately healthy	Unhealthy	Very unhealthy

How many glasses of water do you drink per day? _____ Is this filtered water? Yes | No

Do you drink coffee or tea? Yes | No How many cups per day? _____

Do you smoke? Yes | No If yes, how many cigarettes per day? _____

Are you currently on any medication? Yes/No If yes, what? _____

Have you ever been on any long-term medication? Yes/No If yes, what? _____

Have you ever been hospitalized or had surgery? Yes/No If yes, why & when? _____

In the past few months have you experienced any of the following? (Please circle any that apply)

Unexplained changes in weight | Observable changes in moles or skin | Change in bowel or bladder habits | Pain at night | Sores that won't heal | Nagging cough | Unexplained Night sweats

Have you ever suffered a heart attack or had a stroke? Yes/No

Do you frequently suffer from any of the following: (Please circle any that apply)

Fatigue/Tiredness	Grumpiness	Irritability	Anxiety/Nervousness
Depression	Poor concentration	Insomnia/Poor sleep	Negative thoughts/attitude
Hyperactivity	Anger	Low motivation	Easily losing patience

Have you ever experienced an emotionally traumatic event or a period of severe stress or grief? Yes | No

If yes, when & why?_____

How would you rate your current level of stress?

1	2	3	4	5
Very High	High	Moderate	Low	Very low

Is there any further information you would like us to know? _____

_____

AUTHORISATION FOR CARE

As with all health care professionals the law now requires practitioners who adjust the spine to inform patients of material risk. Chiropractic adjustments of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and many other alternatives. (A risk assessment of cervical manipulation, JMPT, 1995. Magna Report, Ontario Ministry of Health, 1993). In extremely rare circumstances some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke like symptoms. This is extremely rare occurring in approx.. 1 in 5.85 million (Haldeman, et al. Spine, 1999, Vol 24-8). Whilst this has never occurred in this practice, we are still required to impart this information. Before you receive any adjustments, you will be tested to minimise risk, as has always been our practice. If you have any questions related to the care you are about to receive please speak to the chiropractor.

X-rays may be required in order to complete our examination and give us the most detailed information about the health of your spine. For safety purposes, female patients please answer the following questions: Are you pregnant or trying to get pregnant? Yes/No When was your most recent period?

Please sign below if you give permission for the chiropractor to examine and administer care as deemed necessary. For patients under the age of 18, a parental guardian must sign below.

Signature: _____ **Date:** _____