WELCOME

New Practice Member Intake Form

Name: _____ Date of birth: _____ Age: _____

Address:_____ Town: _____Postcode: _____

Email: _____

Please tick if you would like to receive updates via Email on our wellness seminars and other exciting events ☐

Telephone: H: _____ W: _____ M: _____

What is your preferred way of us contacting you? ☐ Phone ☐ SMS ☐ Email

Name of G.P: _____ Who may we thank for referring you to us? _____

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

Previous Chiropractic Care? Yes / No With who & when?_____

PLEASE ANSWER ALL 4 PAGES AS ACCURATELY AS POSSIBLE.

What are your main health concerns that bring you here today? _____

_____

_____

Do you have any other health concerns or known illnesses? YES / NO If yes, what? _____

_____

Please answer the following Vitality questions and rate yourself.

In general, how is your sleep?

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

In general, how would you rate your Digestion?

1	2	3	4	5
Excellent	Very Good	Good	Fair	Poor

In general, how would you rate your health?

1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

Doctor's Notes:

The following sections relate to 3 Main Stress groups; Physical, Chemical & Emotional. Please answer the Questions to your best knowledge.

Physical Stress

Please list any accidents or injuries that you have suffered, even those that you consider minor. Include when and how they occurred. Consider, if you have you ever broken any bones, had a head injury, a fall, or been involved in a motor vehicle, horse riding, sports or bike accidents?

When (e.g. March 1997)	Type of Trauma (e.g. fall)	Injured Area (e.g. Neck)	Action taken (e.g. A & E)

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

What level of activity is the exercise? Vigorous activity Moderate activity Light

Prolonged abnormal posture or subtle repetitive movements often place stress on our spine.

How would you describe your posture? (eg. hunched, normal, weak, lopsided) _____

Does your typical day involve any of the following? (Please circle)

Heavy lifting / Repetitive movements / bending / Vigorous activity / Shift work / Prolonged sitting.

If prolonged time sitting – is it in front of a computer? YES / NO

Chemical Stress

In general, how would you rate what you eat / Nutrition?

1 2 3 4 5

Very healthy Healthy Moderately Healthy Unhealthy Very unhealthy

Do you have regular Bowel movements? YES/NO How often? _____ / Day _____ / Week How many glasses of water do you drink per day? _____ Is this filtered water? YES / NO Do you drink Fizzy/Energy drinks? YES / NO How often? _____ / Day _____ / Week

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

Do you drink alcohol? YES / NO How often? _____ / Day _____ / Week

Do you use recreational drugs / suffered with addictions? YES / NO Details: _____

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

Do you/have you worked with chemicals (e.g. Pesticides)? YES / NO How long ago? _____

Are you currently on any medications? Yes / No Are they PRESCRIBED / OVER THE COUNTER

If yes, what?_____

_____

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

Have you ever been hospitalized or had surgery? Yes / No If yes, please fill in the following:

When? (e.g. June 2005)	What body part? (e.g. Gallbladder)	Action taken? (e.g. Removed)

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 or are at risk of a heart attack or a stroke? YES / NO _____

Emotional Stress

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 emotional stress?

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

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

_____

Do you suffer from: (Please circle items you can relate to)

Shoulder and neck tightness	**Sensitivity to light or noise**	**Headaches/migraines**	**High blood pressure**
Light sleep & vivid dreams	**Problems with inflammation**	**Gallbladder problems**	**Thyroid problems**
Digestive upsets	**Bloating / IBS**	**Diarrhea/Constipation**	**Allergies**
Polycystic Ovarian Syndrome	**Hormone imbalances**	**Uterine Fibroids**	**Infertility**

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?____

NB: The purpose of today's visit is to check you, not treat you, unless it is an Emergency.

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: _____

WELCOME TO LIVING CHIROPRACTIC AND WELLNESS - Tuakau

As a team we are focused on, and committed to, spreading the chiropractic message to the whole community. We strive to provide loving service to our patients and their families, and look forward to supporting you on your journey to greater health and wellbeing.

Chiropractor's Signature: _____

Living CHIROPRACTIC AND WELLNESS