68 The Mount, York, YO24 1AR
01904 659679
www.chiropractic1st.co.uk
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We are a family practice transforming the health of the community through chiropractic and lifestyle adjustments. For us to properly understand your health problem we need information about your present concerns. We also require information about your general health and lifestyle habits. Thank you.

Name: _____

Address: _____ Post Code: _____

Date of Birth: _____ Age: ____ Email: _____

Home Phone No: _____ Mobile No: _____

Employer: _____ Occupation: _____

Marital Status: Married / Single / Cohabiting/ Widowed / Divorced

Name of Spouse/Partner: _____Occupation: _____

Number of children, names and ages: _____

GP's Name: _____Clinic: _____

May we have your permission to update your medical doctor regarding your care here, if relevant? Y / N

How did you find out about us? Friend –_____/ Internet/ GP/ Walk by/ Private Healthcare

Current Health

I would like help for: _____

When did the symptoms start?_____ Have you experienced similar symptoms before? Y/N When?_____

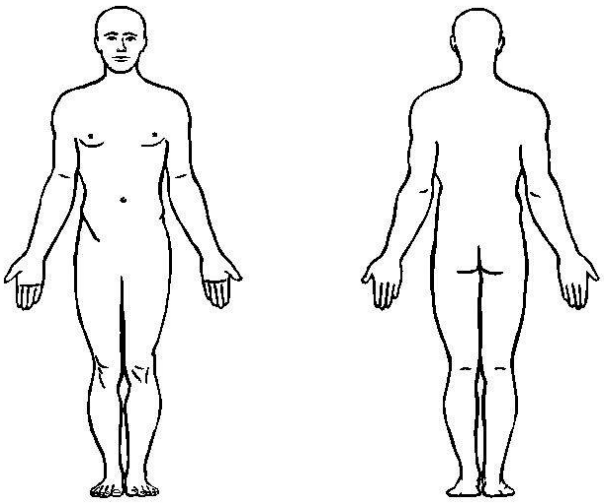
Please rate your current pain on a scale of 1-10 (0 being No Pain and 10 Worst Pain Imaginable)_____

What makes this pain worse? _____

What makes this pain better? _____

What type of pain is it? sharp/numb_____

Does the pain radiate or travel (to where)?_____



For official use only notes:

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE MARK AREAS OF PAIN WITH AN X
ON THE FRONT AND BACK IMAGES

Current Health cont.

Is the pain worse A.M or P.M.? _____

Have you seen other healthcare providers for this complaint? Y / N G.P. / Consultant / Physiotherapist / Other

Results: _____

Have x – rays or other images taken ever been taken? Y / N What were the results?

_____

Other problems I am concerned with: _____

_____

Please list any drugs / medicines / painkillers you are taking on a regular basis:

_____

Tick if appropriate: □ Recent infection □ Night sweats □ Pain at night that wakes you up

Medical History

Have you had any traumas since you were born? (car accidents, Sports, childhood incidents, mode of birth, slips/falls)

_____

_____

Have you had any surgery's?

_____

_____

Have you had any Major Illness's?

_____

Have you ever had chiropractic care? Y/N

Please check each of the conditions you have currently, or have had in the past:

□ Blurred vision
□ Light sensitivity
□ Ringing of ears
□ Congested sinus
□ Headaches/Migraines
□ Loss of balance
□ Fainting
□ Neck pain
□ Thyroid (under/over active)
□ Difficulty breathing
□ Chest pain
□ High blood pressure
□ Pacemaker
□ Stroke
□ Cancer
□ Osteoporosis/bone density loss
□ Loss of smell

□ Low Back Pain
□ Shoulder/Arm pain
□ Pain between shoulders
□ Arthritic pain
□ Ulcers/Colitis
□ Allergies
□ Asthma
□ Numbness
□ Digestive problems
□ Heartburn/indigestion
□ Loss of sleep
□ Knee/foot pain
□ Swelling
□ Diabetes
□ Epilepsy
□ Blood disorder
□ Loss of taste

□ Loss of Appetite
□ Unexplained weight loss
□ Excessive thirst
□ Irregular menstrual flow
□ Hot flushes
□ Breast soreness/lumps
□ Loss of bladder control
□ Frequent urination
□ Painful urination
□ Constipation
□ Dermatitis/eczema/rash
□ Depression/anxiety
□ Gout
□ Bladder infection
□ Gallbladder/kidney problems
□ Numbness around the groin
□ Seizures

Other:_____

Health Lifestyle

Your lifestyle choices affect the efficiency to which your body will heal. Please fill in the following so we can make our best recommendations to support the healing process.

How are your symptoms affecting your quality of life? *(I.e. hobbies, exercise, work, sleep, family time,)*

_____

_____

How many hours a week do you work? _____ Do you enjoy your job? Y/N

How many hours sleep, on average, do you get each night? _____

Do you exercise? Y/N How Often? _____

Types of exercise: _____

Do you drink tea/coffee? Y/N Amount per day: _____

Do you drink alcohol? Y/N Amount per day: _____

Do you drink fizzy drinks? Y/N Amount per day: _____

Do you use tobacco? Y/N _____ per day/week (circle one)

How much water do you drink per day? _____

How many servings of fruit & veg do you eat a day? _____

How many hours of TV do you watch a day? _____

How many hours a day do you spend in front of a TV or computer outside of work? _____

Please list any vitamins/ supplements you take:

_____

_____

Are you happy with your current weight? _____If No, reason why?_____

Please rate your stress levels on a scale of 1-10 (10 being the highest) _____

Please rate your general health on a scale of 1-10 (10 being excellent)

Do you want to: □ Improve Your Health □ Get Pain Relief □ Both ?

Print Name: _____I can confirm that the above is a full and accurate disclosure of my health and medical status.

Signature_____ Date_____

I authorise Arleen Scholten DC to examine and adjust my spine/extremities/cranium as she deems appropriate, (or a locum doctor authorised by Arleen Scholten DC, in her absence) through the use of Chiropractic methods.

Signature: _____Date: _____