Welcome to the family

CONFIDENTIAL HEALTH AND WELLNESS QUESTIONNAIRE

Our team believes that health is more than just how you feel. True health and wellness means you are physically, mentally and emotionally at your best.

ABOUT YOU

Full name ____ Date _______________

I prefer to be called_______________________________

Address ____

____ Postcode ___________

Telephone H _______________ W _______________ M _______________

Email ____

Date of birth _______________ Age _______________

Name of spouse / partner / guardian ___________________________________

Number of children __________ Are you currently pregnant? (females only) Y / N

Your occupation ____

Previous occupations (if applicable)______________________________________

What do you enjoy doing most in life? ____________________________________

What sort of exercise do you do? ____

Who may we thank for referring you?_____________________________________

PAST HEALTH HISTORY

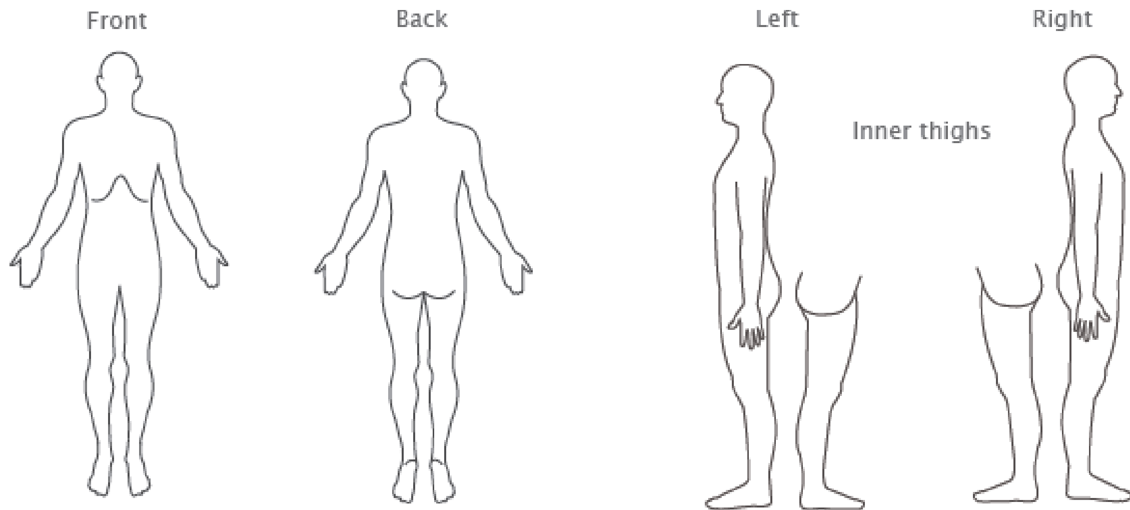
Please tick (√) the following conditions you have presently and cross (X) the conditions you have had previously.

☐	Heart disease	☐	Epilepsy	☐	Sinus problems	☐	Concussion
☐	High blood pressure	☐	Eczema	☐	Low immunity	☐	Arthritis
☐	Breathing difficulty	☐	Thyroid problems	☐	Dizziness	☐	Allergies
☐	Asthma	☐	Neck pain	☐	Ringing in ears	☐	Fracture
☐	Digestive complaints	☐	Mid back pain	☐	Depression	☐	Cancer
☐	Numbness/Tingling	☐	Low back pain	☐	Anxiety	☐	
☐	Diabetes	☐	Headaches/Migraines	☐	Low energy	☐	

CURRENT HEALTH

Why have you come to see us today? ____

Please mark below any areas of concern, pain or discomfort.



How long have you had this problem? ____

How did this problem start? ____

Have you had this before? ____

What makes this problem better? ____

What makes this problem worse? ____

What treatment(s) have you used? ____

<u>**Office use only:**</u>

Read codes: Images needed Y/N

GENERAL HEALTH HISTORY

Have you had any x-rays before? (which body part) ____

Have you had CT scans or MRI's before? (which body part)_________________________________

What medications are you currently taking? ____

What supplements are you currently taking? ____

Have you had any major accidents, injuries or illnesses in the past? ___________________________

____

____

Have you ever been hospitalised? What for? ____

____

Have you ever seen a chiropractor before?____

Who did you see and when was your last appointment? __________________________________

FAMILY HISTORY

Are there any health conditions that run in your family? ___________________________________

LIFESTYLE

Which is your dominant hand? ____

What is your most comfortable position to sleep at night?_____________________________

Have you previously or currently smoke cigarettes? ______________________________________

INFORMED CONSENT

I consent to a professional and complete chiropractic examination and any care the chiropractor deems necessary. I consent for my information being shared within the practice.

Print your name: ___________________________________

Signature: ___________________________________