Welcome to the family

OMEGA Chiropractic & Radiology

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_____ Gender: M / F

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

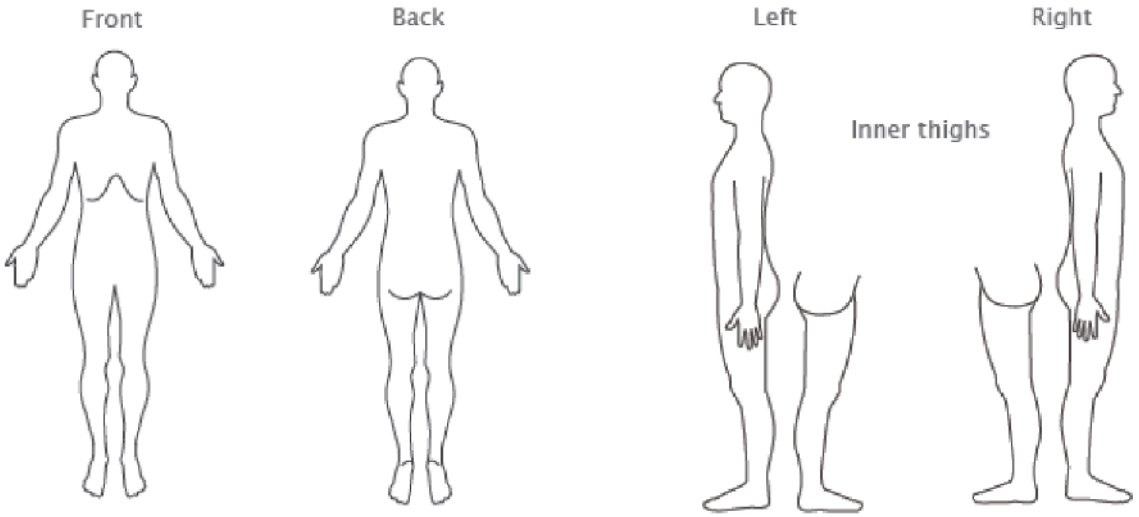
Please tick (√) the following conditions you have presently and cross (X) the conditions you have had previously.

☐ 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? _____

Office use only:

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?_____

Do you currently smoke cigarettes, e-cigarettes or vape?_____

Have you previously smoked cigarettes, e-cigarettes or vaped? Yes / No

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: _____