HADFIELD
CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

FULL NAME ....

PREFERRED NAME ....

DATE OF BIRTH .... AGE .... M ☐ F ☐ NUMBER OF CHILDREN ....

ADDRESS ....

PHONE (H) .... (W) .... (M) ....

EMAIL ....

EMERGENCY CONTACT (name/phone) ....

GP/CLINIC ....

OCCUPATION ....

PREVIOUS OCCUPATIONS ....

How were you referred to our clinic? SELF ☐ FRIEND/FAMILY ☐ WEBSITE ☐

OTHER ....

PRESENTING COMPLAINT

What is the main reason for your visit today? ....

....

When did this condition start? ....

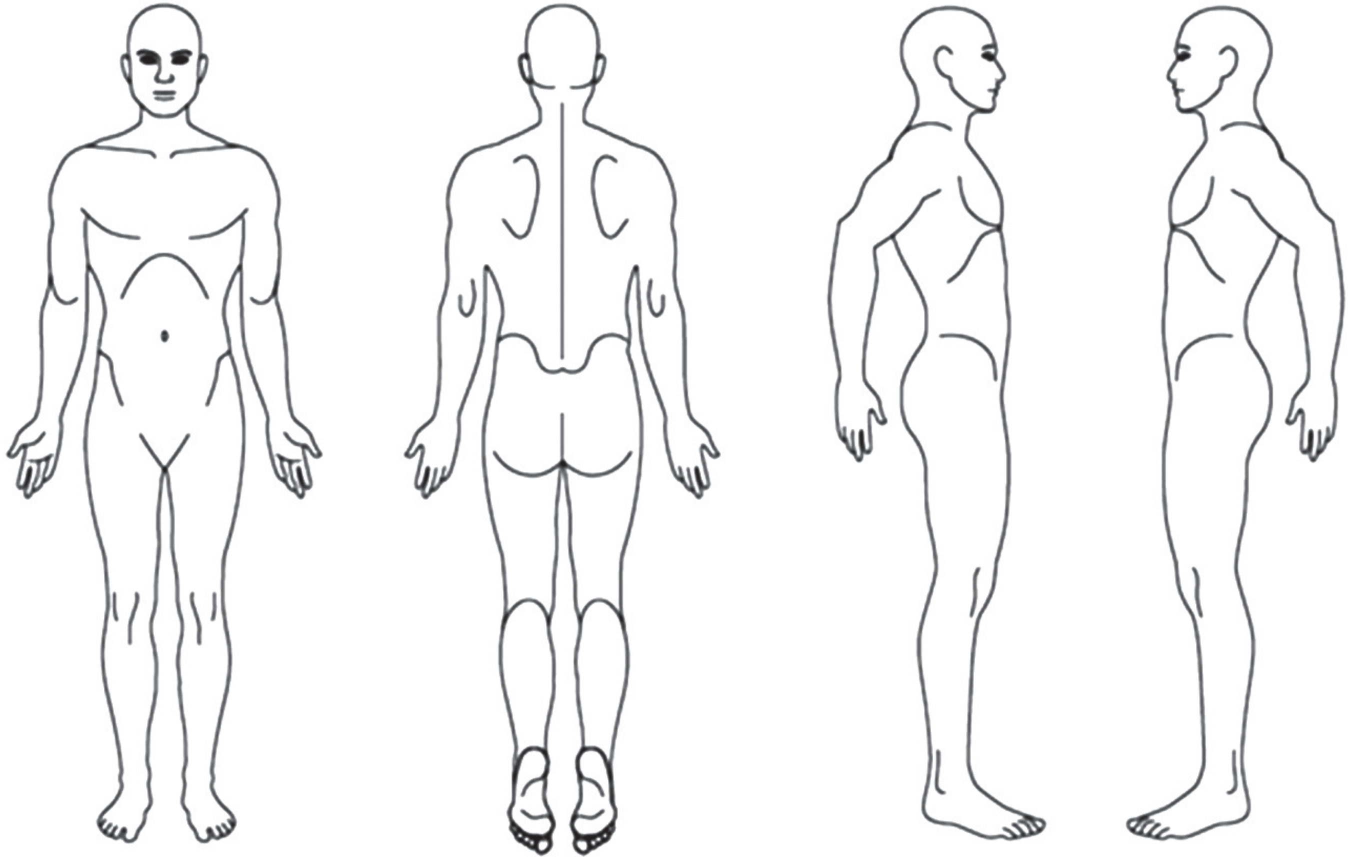
Did anything happen to trigger this condition? ....

Rate of severity *(please circle)* (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

Appropriate descriptions: Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Tingling ☐ Ache ☐ Stiff ☐

Improving ☐ Worsening ☐ Same ☐ Constant ☐ Intermittent ☐

Please indicate on this diagram area of pain or concern:



What makes this condition worse? ....

What makes it better? ....

Have you consulted any other health practitioners for this condition or had prior treatment?

....

Have you had similar symptoms in the past? ....

Are there any other problems you are concerned with? ....

Have you visited a Chiropractor before? ....

If so, who, and when was your last adjustment? ....

GENERAL HEALTH HISTORY

Are you on any medication (for any condition)? ....

Do you take any supplements regularly? ....

Do you have a history of surgery (for any reason)? Please indicate reason and date:

....

Have you had any Motor Vehicle Accidents or other major Injuries? ....

Have you had previous imaging (xray/CT/MRI) ....

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

Are you pregnant or attempting to become pregnant (females only)? Y ☐ N ☐

Please **TICK** the following conditions that you have, and **CROSS** the conditions that you have had in the past:

☐ Heart disease	☐ Neck pain	☐ Low energy
☐ High blood pressure	☐ Thoracic/rib pain	☐ Thyroid problems
☐ Low blood pressure	☐ Low back pain	☐ Fibromyalgia/Polymyalgia
☐ High cholesterol	☐ Headache/Migraine	☐ Chronic Fatigue Syndrome
☐ Asthma	☐ Dizziness	☐ Concussion
☐ Breathing problems	☐ Tinnitus (ear ringing)	☐ Arthritis
☐ Digestive problems	☐ Sinus problems	☐ Allergies
☐ Diabetes	☐ Numbness/Tingling	☐ ASD / ADHD
☐ Epilepsy	☐ Depression	☐ Fracture
☐ Eczema	☐ Anxiety	☐ Cancer

LIFESTYLE

Do you do regular exercise? ....

What are your favourite hobbies? ....

Are you your ideal weight? ....

Do you smoke cigarettes/vape? Y ☐ N ☐

Do you believe you have adequate water intake? Y ☐ N ☐

Do you drink alcohol? Y ☐ N ☐ Units/wk ....

Do you drink caffeine? Y ☐ N ☐ Units/day ....

What is your dominant hand? L ☐ R ☐ Ambidextrous ☐

What is your most comfortable sleeping position at night? Back ☐ Stomach ☐ Side lying ☐

INFORMED CONSENT

I have filled in this form to the best of my knowledge. I hereby give consent to undergo a chiropractic consultation and examination, and to undergo any treatment deemed appropriate by my practitioner. I consent to the use and disclosure of my personal information to other health professionals involved in my care.
I understand that no accounts are rendered at Hadfield Chiropractic, and all treatment fees are due at the time of service. ACC Patients: I understand that if my claim is declined, I am liable for any outstanding charges.

Signature ....

Print Name ....

Date ....