Elements Chiropractic Initial Health Assessment

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Suburb: _____ Postcode: _____

Phone No: _____ Mobile: _____ Work: _____

Email: _____ Occupation: _____

Relationship Status: _____ No. & age of children: _____

Private Health Insurance Y / N Name of Health fund: _____

How did you hear about Elements Chiropractic? _____

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What is your primary reason for seeing a chiropractor at Elements Chiropractic?

_____

How long have you had this concern? _____

How does this concern affect your life (0 = not at all, 1 = slightly , 2 = moderately 3 = severely)

Work	0 1 2 3	Recreation	0 1 2 3	Rest/Sleep	0 1 2 3	Family/Kids	0 1 2 3
Sitting	0 1 2 3	Productivity	0 1 2 3	Mood	0 1 2 3	Relationship	0 1 2 3
Walking	0 1 2 3	Social Life	0 1 2 3	Energy	0 1 2 3	Tolerance	0 1 2 3
Exercise/Sport	0 1 2 3	Love life	0 1 2 3	Concentration	0 1 2 3	Happiness	0 1 2 3

What outcome do you hope to achieve from seeing a Chiropractor? _____

_____

What do you think it would take to achieve this? _____

_____

Do you have any other health concerns / pains / conditions? _____

_____

Have you or are you seeing any other health professionals? (please circle)

Chiropractor GP Surgeon/Specialist Massage Therapist Naturopath
Physiotherapist Osteopath Acupuncturist Other _____

If yes why? _____

_____

Have they helped?_____

Are you currently taking any medications or supplements? If yes please list and why: _____

_____

How do you currently manage the stresses in your life? _____

_____

Symptoms (such as listed below) may be the last indicators that something is wrong. By the time these signals have appeared, the conditions may have been developing for a long time. If you do have any of the following, they may help us in the analysis of your health status. Please circle PAST or CURRENT.

HEAD
P C Headaches
P C Migraines
P C Jaw problems
P C Earache
P C Ear ringing
P C Ear buzzing
P C Eye pain
P C Dental decay
P C Gum trouble
P C Sinus blockage

NECK
P C Pain
P C Numbness
P C Stiffness
P C Weakness
P C Grating sensation

UPPER &/OR MIDDLE BACK
P C Pain
P C Numbness
P C Stiffness
P C Tightness
P C Swelling
P C Weakness

LOWER BACK
P C Pain
P C Numbness
P C Stiffness
P C Weakness
P C Swelling

VITALITY
P C Loss of Sleep
P C Loss of energy
P C Loss of Strength
P C Excessive fatigue

SHOULDER/ARM (specify which)
P C Pain
P C Numbness
P C Stiffness
P C Pins & needles
P C Swelling

ELBOW/WRIST/HAND (specify which)
P C Pain
P C Numbness
P C Stiffness
P C Pins & needles
P C Swelling

HIP/THIGH (specify which)
P C Pain
P C Numbness
P C Stiffness
P C Pins & needles
P C Swelling

KNEE/LEG/ANKLE/FOOT (specify which)
P C Pain
P C Numbness
P C Stiffness
P C Pins & needles
P C Swelling

MIND
P C Nervousness
P C Poor Concentration
P C High Anxiety
P C Easily Stressed
P C Emotional
P C Moody
P C Irritable
P C Depression
P C Pessimism
P C Nightmares

CHEST &/OR ABDOMEN
P C Asthma
P C Bronchitis
P C Wheezing
P C Difficult breathing
P C Shortness of breath
P C Chronic cough
P C Heart problems
P C High blood pressure
P C Low blood pressure
P C Excessive hunger
P C Poor appetite
P C Excessive belching
P C Excessive wind
P C Nausea
P C Vomiting
P C Constipation
P C Diarrhea

SENSES
P C Loss of memory
P C Loss of smell
P C Loss of taste
P C Loss of sight/vision
Do you wear glasses/contact lenses?
Yes No
P C Loss of hearing
Do you wear a hearing aid?
Yes No

GENERAL
P C Allergies/Hay fever
P C Fainting
P C Dizziness
P C Poor posture
P C Scoliosis
P C Sudden weight loss
P C Sudden weight gain
P C Skin problem(s)

FEMALES ONLY

Do you suffer from menstrual cramps or pain? _____

Is your cycle regular? If not explain: _____

Are you/ have you using contraception? (Please circle) The Pill Mirena Implant Other

Have you ever given birth? Yes / No If yes when? _____

How was your pregnancy? _____

How was your delivery? _____

Any interventions (epidural, caesarean, forceps, vacuum) _____

Have you ever miscarried? _____

Any chance you are pregnant? Yes / No / Unsure

Are you currently planning to become pregnant? _____

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How would you describe your energy levels? High / Average / Fluctuating / Low

How would you describe your sleep quality? Poor / Fair / Good / Excellent

How would you describe your physical health? Poor / Fair / Good / Excellent.

It is currently: Improving / Declining / Staying the same

How would you describe your mental / emotional health? Poor / Fair / Good / Excellent.

It is currently: Improving / Declining / Staying the same

Would you consider yourself to be physically, chemically or emotionally stressed? Yes / No

Emotional Stress:

The following situations can easily create emotional /mental stress. Please circle if you have experienced stress from any of the following? Provide details if you wish

Loss of loved one past / currently _____

Seperation / Divorce past / currently _____

Family / relationship stress past / currently _____

Parents /sibling stress past / currently _____

Emotional or Physical Abuse past / currently _____

Rapid change in life situation past / currently _____

Change of job past / currently _____

Moving house past / currently _____

Moving schools past / currently _____

Legal concerns past / currently _____

Financial concerns past / currently _____

Major ongoing illness past / currently _____

Other past / currently _____

Chemical Stress:

Please circle if you have experienced stress from any of the following

Cigarettes Currently In the past

Regular consumption of Alcohol: Currently In the past

Social drugs: Currently In the past

Prescription / non-prescription medication: Currently In the past

Consumption of sugar: Currently In the past

Exposure to chemicals / fumes / smoke: Currently In the past

Physical Stress:

Have you ever had surgery or been hospitalised? Yes / No Please list what was done and when:

_____

Have you ever been involved in a motor vehicle accident or other major accident? Yes / No

Please describe _____

Have you ever broken any bones? Yes / No _____

Have you ever had a concussion? Yes / No _____

Did you / do you play competitive sport? Yes / No _____

Are you aware of any physical stress / trauma during your birth? _____

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Congratulations on choosing Elements Chiropractic for your chiropractic care. Your health is important to us and we look forward to working with you to a healthier happier you! If there are any changes you are making for your body and health that we can support you with (ie- starting exercise, meditation, changing diet) please let us know.

_____

_____

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To keep you abreast of news, developments and activities at Elements Chiropractic, you will be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities, special events and like, etc. Additionally, we may contact you in relation to your care. We require your permission to contact you, be it by post, fax, email, telephone, or otherwise. If you have not already given us your email address, please do so now on page one, so we may be able to keep you up to date. Your signature below indicates your permission for us to communicate with, and to you.

Signature: _____ **Date:** _____