Naturally Chiropractic

Adult new patient medical history

a: 1a St Oswins Place, Tynemouth NE30 4RQ
t: 0191 259 6777
e: info@naturally-chiropractic.com

Title: .... Surname: ....

First Name(s): .... Preferred Name: ....

Address: ....

.... Postcode: ....

Occupation: ....

Phone No: ....(Day) ....(Evening) ....(Mobile)

Date of Birth: ....Age: ....

Marital Status: .... Partner: ....

Names of children and ages: ....

Name of G.P: ....

Have you ever received chiropractic care? *yes* ☐ *no* ☐ *please tick*

Why are you here? ....

....

....

....

How did you hear about Naturally Chiropractic? ....

....

Your body is designed to be healthy. There is always a cause or reason to why it is not. Throughout life many events occur that may damage your health.

The following questions will help us assess any layers of damage, particularly to your nervous system, that have adversely affected your health. All information will be handled in the strictest of confidence. Please tick where appropriate.

Your Birth

The birth process can be quite traumatic on both mother and baby and is often where spinal damage may first occur.
Was your birth:

Unassisted	☐	Forceps/Suction	☐	Caesarean	☐	Short duration	☐
Premature	☐	Induced	☐	Breech	☐	Drug assisted	☐
Prolonged labour	☐	Unsure	☐				

Your Childhood

Children often display symptoms of decreased health which may stem from spinal problems and/or nerve pressure.
As a child did you suffer from:

Colic	☐	Bedwetting	☐	Ear Infections	☐	Mumps	☐
Allergies	☐	Asthma	☐	Eczema	☐	Tonsillitis/throat infection	☐
Measles	☐	German Measles	☐	Chicken Pox	☐	Other	☐

As a child were you:

Breast fed ☐ A restless sleeper ☐ A head banger ☐

As a child did you:

Have any major accidents ☐ Have surgery ☐ Require medication (prescribed/other) ☐

Crawl before walking ☐ Use a baby walker ☐ Use a baby bouncer ☐

Have a chair pulled from under you ☐ Fall down stairs ☐ Sleep on your stomach ☐

Use callipers ☐ Have flat feet ☐ Have turned feet ☐

Were you vaccinated as a child: *yes* ☐ *no* ☐ unsure ☐

Women Only

Reproductive issues can place a strain on your body's resources. Chiropractic can help redress the balance.
Have you had/Do you have:

Period pain/discomfort ☐ PMT ☐ Irregular periods ☐ Chronic thrush ☐

Have you experienced any fertility problems (please give details)? ....

....

....

Number of full term pregnancies .... Number of pregnancies not to term ....

Have you experienced any problems throughout pregnancy (please explain) ....

....

or with the birth (give details) ....

....

....

Have you been on the oral contraceptive pill? *yes* ☐ *no* ☐ for how long? ....

Accidents

Have you ever suffered:

Broken bones	☐	Age?	Motor vehicle accidents	☐	Age ....
Fainting/Unconsciousness	☐	Age?	Sprains	☐	Age ....
Other	☐	Age?	Please give details		....

....

....

As the core problems get coated with more & more layers of damage, symptoms & bouts of sickness arise, displaying decreasing adaptability & health.

General Health

Have you ever suffered from an illness which required hospitalisation or long term medication?

Describe ....

....Age ....

Do you take any medication/drugs (*prescription/non prescription*)

Medication: .... What for .... How long? ....

....

....

....

Have you ever had surgery either as a child or an adult?

Tonsils	☐	Appendix	☐	Adenoid's	☐	Hysterectomy	☐
Other	☐	....					

....

Have you ever had x-rays, scans or MRI (Please give dates & details)? ....

....

Have you had/Do you have:

Headaches	☐	Chest pains	☐	Cold sweats	☐	Cystitis/bladder infections	☐
Dizziness	☐	Palpitations	☐	Loss of balance	☐	Loss of consciousness	☐
Eye problems	☐	Heart attacks/angina	☐	Loss of smell/taste	☐	Arthritis/joint swelling	☐
Loss of vision	☐	High blood pressure	☐	Diabetes	☐	Difficulty breathing	☐
Hearing problems	☐	Low blood pressure	☐	Jaw pain/clicking	☐	Asthma	☐
Strokes/T.I.A.'s	☐	Varicose veins	☐	Teeth grinding	☐	Sinus problems	☐
Pins and needles	☐	Fatigue/tiredness	☐	Orthodontic work	☐	Allergic reactions	☐
Numbness	☐	Diarrhoea & constipation	☐	Teeth removed	☐	Eczema/skin problems	☐
Indigestion	☐	Cancer	☐	Prostate problems	☐	Epilepsy/fits/seizures	☐
Swelling of ankles	☐	Rapid weight loss	☐	Difficulty urinating	☐	Other	☐
Do you suffer with:		Occupational Stress	☐	Physical stress	☐	Mental stress	☐

Nutrition

DO YOU:

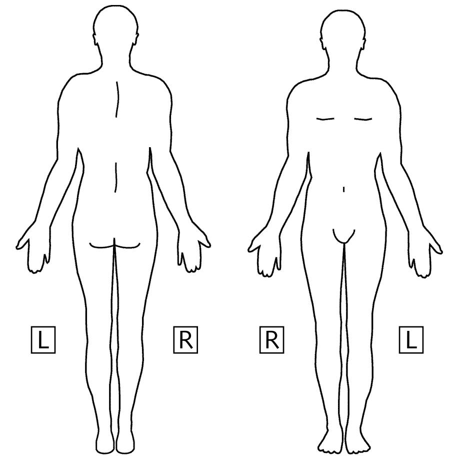
Smoke:	yes ☐	no ☐	number per day?	....
Drink alcohol:	yes ☐	no ☐	Glasses (not pints) per week?	....

Drink water:

0-1 glass per day	☐	1-3 glasses per day	☐	4-8 glasses per day	☐	more	☐
Eat <u>fresh</u> vegetables:		0-3 servings per week	☐	at least 1 per day	☐	several per day	☐
Eat <u>fresh</u> fruit:		0-3 servings per week	☐	at least 1 per day	☐	several per day	☐

Is there a family history of:

	Heart disease	Arthritis	Cancer	Diabetes	Other
Father	☐	☐	☐	☐	....
Mother	☐	☐	☐	☐	....



Are you suffering any pain or illness conditions at the moment? ....

....

....

....

....

Describe them and indicate areas on the diagrams ....

....

....

....

Indicate on the following scale how you would rate your pain/discomfort on a scale of 1-10:

1 10

No pain Extreme pain

Which sports, hobbies or leisure activities do you engage in:..

....

....

....

What is your sleeping posture? Side ☐ Stomach ☐ Back ☐

Number of hours of quality sleep per night? ....

How many pillows do you use?...How old is your mattress?...

On a scale of 1-10 how would you rate your health:

1 10

Poor Health Excellent Health

Reasons: ....

....

....

....

....

Thank you for taking the time to fill in this form.

Declaration: The above information is to the best of my knowledge true & correct.

I have read and understood the 'Informed Consent' form and agree to proceed with care at Naturally Chiropractic.

Signed: ....Date: ....

If under 18, I consent for ....to receive chiropractic care.

Signature of parent/guardian:..Date: ....