Booval Chiropractic Today's date:........................

Please print clearly, and be thorough. Thankyou! Please note this form has <u>two</u> sides.

First Names.. Family Name:...

Address:..Pcode:.......

Age....... Date of Birth ...../...../...... Marital Status................. Title........... No. of Children...........

Occupation...Work Tel......................... Home Tel...........................

Mob...................... Email:... Date of last Chiropractic Care....................

How did you learn of the Clinic?..

What kind of Chiropractic Care do you prefer (please tick)?

(...) Relief Care only (this is more likely to be temporary)
(...) Relief and Correction (this tends to improve overall health and to be more permanent)
(...) Preventive/Well-ness Care

Please list the problems for which you seek help today:

1.. 3 ....

2.. 4 ....

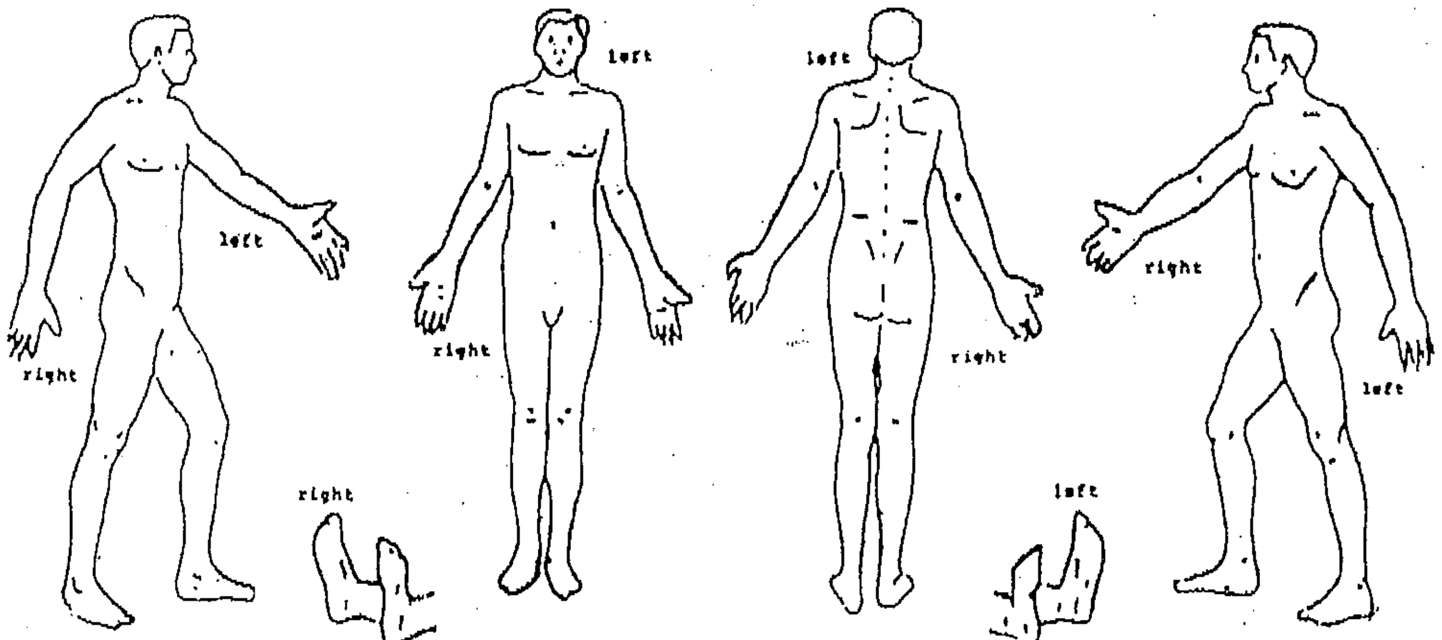
Pain Severity

Please make a SINGLE mark through a line at a point showing how bad the pain is now:

Problem 1. No Pain I--I Unbearable Pain
Problem 2. No Pain I--I Unbearable Pain
Problem 3. No Pain I--I Unbearable Pain
Problem 4. No Pain I--I Unbearable Pain

Pain Chart

Please <u>SHADE</u> the pain areas. DO NOT use arrows or circles.



List ALL drugs/medicines you take...

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List ALL operations (dates, too)..

List ALL x-rays (dates, too)..

List ALL accidents (dates, too)..

TICK what you HAVE NOW, and UNDERLINE what you HAVE HAD in the last FIVE years

Alcoholism	Dizziness	Earache
Allergy	Diabetes	Sexually transmitted disease
Anxiety/depression	Convulsions	Painful sex
Arm pain	Bowel trouble	Gout
Arthritis	Tinnitis	Ankle swelling
Joints swollen	Digestive difficulties	Menstruation painful
Abdominal pain	Spinal curve	Menses irregular
Knee pain	Scoliosis	Hot flushes
Leg pain	Fever	Breast lumps
Chest pain	Fatigue	Vomiting blood
Elbow pain	Cancer	Thrombosis
Ankle pain	Hoarseness	Low blood pressure
Hip pain	Asthma	High blood pressure
Foot trouble	Difficulties breathing	Stroke
Hand pain	Scarlet fever	Heart disease
Headache	Gall bladder trouble	Drug dependence
Jaw pain/clicking	Urinating frequently	Epilepsy
Low back pain/stiffness	Urinating pain	Relationship stress
Midback pain	Swallowing difficulties	Job stress
Migraine	Kidney trouble	Other stress
Neck pain/stiffness	Deafness	Other (please explain).............
Shoulder pain	Prostate trouble	....

How much do you smoke?................. What exercise do you get?.......................................

How much alcohol do you consume weekly........... How many alcohol-free days weekly.....

Do you sleep well?............... How much coffee/cola do you consume daily?.......................

Do you eat a full breakfast daily?......Is your diet good (fresh fruit, vegetables etc daily)?............

Is there anything else we should know about you or your health (please explain) ....

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Thankyou for being thorough.